| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44890<br><br>Based on record review, and resident and staff interviews, the facility failed to ensure residents' rights to maintain dignity for 2 of 2 residents reviewed for dignity. On the night of admission, Resident #242 informed Nurse Aide (NA) #9 she needed to use the bathroom, and NA #9 told her to just go in the bed. This resulted in the resident having to urinate in the bed, crying, and making her feel useless, bad and embarrassed. Additionally, NA #9 provided incontinence care to Resident #75 while he was in his room, standing up over his wheelchair, holding onto a walker. Resident #75 felt this was rude and insensitive.<br><br>The findings included:<br><br>1) The Hospital Discharge Summary written by the hospital physician on 1/29/2025 for Resident #242 revealed she was admitted to the hospital on 1/22/2025 with acute respiratory failure with hypoxia (low oxygen levels). She was discharged from the hospital to the facility for rehab on 1/29/2025.<br><br>Resident #242 was admitted to the facility on [DATE] with a diagnosis of hypertensive heart disease with heart failure and stage 4 chronic kidney disease.<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #242 was cognitively intact. She was coded for being occasionally incontinent of urine and frequently incontinent of bowel and required the assistance of 1 staff member with transferring and toileting.<br><br>A Psychiatric Follow-Up Evaluation written by the Psych Physician Assistant (PA) on 2/6/2025, listed the chief complaint/ nature of presenting problem was Resident #242 reported a distressing incident with a Nurse Aide (NA) during admission last Wednesday night. It further read that the resident felt she was verbally abused by the NA because she was loud and rude while performing tasks. It stated an incident occurred during the weighing process while using a sling, she needed to use the bathroom, and the NA instructed her to just go in the bed. It further read that because of the incontinence episode she felt useless at the time but was not feeling any long-term effects. The report indicated Resident #242 was initially referred to Psych Services by the Medical Director because she had been experiencing depression for a year over the death of her son and had never talked to anyone about it.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An interview with Resident #242 was completed on 2/6/2025 at 11:25 AM. Resident #242 stated that she had a really bad experience with a NA on the evening shift on 1/29/2025, when she was admitted to the facility. She further stated that when she was in the hospital she was getting up to the bathroom with assistance and using her walker. Resident #242 stated that NA #9 had refused to take her to the bathroom and told her she had to be evaluated by physical therapy before she could get out of bed. She further stated that NA #9 was slamming things around and yelling at her while performing tasks, such as weighing her in the lift, and changing the bed. Resident #242 stated she was not usually incontinent, and it made her feel bad and embarrassed to urinate in the bed, but she had no choice, because NA #9 did not get her a bed pan in time or get her up to the bathroom. She indicated that NA #9 was rough when touching her and she really felt like she had been manhandled. Resident #242 indicated that nobody should be treated the way she was treated the night she was admitted . Resident #242 stated she was crying and upset, and NA #9 had just slammed the door when she left the room. She further stated that she told the nurse aide on night shift that NA #9 was rude to her, but she didn't tell her the about the incident. Resident #242 indicated that the reason she waited until the next day to tell anyone was because her family member worked at the facility, and she didn't want to cause any problems. She stated she informed her family member about the incident first thing in the morning on 1/30/25, who told her she needed to report the incident to the management, and she did. Resident #242 stated she had never had anybody talk to her like that before and it still upset her.<br><br>A telephone interview was completed with NA #9 on 2/6/2025 at 11:42 AM. NA #9 stated she was the NA that admitted Resident #242 on 1/29/2025 on the 3:00 PM to 11:00 PM shift. She further stated that while she was weighing the resident with the lift she had asked to go to the bathroom. She stated that Resident #242 came by ambulance on a stretcher, and she didn't know if she could walk or not, so she told her she would get her a bedpan. NA #9 indicated that Resident #242 became upset, and she was crying and asking for her walker or a wheelchair to go to the bathroom. She stated that she told Resident #242 she had to be evaluated by therapy before she was able to get out of bed. NA #9 insisted she was not yelling at Resident #242, but that she just talked very loudly. She indicated that Resident #242 told her she was going to report her, but she didn't do anything wrong. NA #9 stated she was on suspension for poor customer service related to this incident.<br><br>A telephone interview was completed with Nurse #7 on 2/7/2025 at 9:31 AM. Nurse #7 stated she was the nurse that admitted Resident #242 on 1/29/2025. She further stated that therapy did not have to evaluate new residents prior to ambulation. Nurse #7 indicated nurses could make that decision based on assessment and report from the hospital staff. She stated that she had told NA #9 that Resident #242 was alert and oriented and she was able to ambulate with a walker or she could take her to the bathroom in a wheelchair, since she was a one-person assist. Nurse #7 indicated that she found out NA #9 refused to take Resident #242 to the bathroom when NA #9 was suspended the next day (1/30/25).<br><br>An interview was conducted with the Admissions Director on 2/6/2025 at 2:30 PM. The Admissions Director stated that she went to Resident #242's room on the morning of 1/30/2025 to complete the admission paperwork. She further stated that Resident #242 had complained to her that a nurse aide was very loud and mean to her the night before. The Admissions Director indicated that Resident #242 appeared sad and stated she was upset, so she had filled out a Concern Form for her and gave it to the Business Office Manager who was the Acting Administrator that day. She stated the Business Office Manager was in charge when the Administrator was out of the building.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An interview was completed with the Interim Director of Rehab on 2/7/2025 at 8:30 AM. The Interim Director of Rehab stated the facility did not have a policy that required therapy to evaluate all new residents prior to ambulation or getting out of bed. She stated the nurses could make that determination based on assessment and clinical evaluation.<br><br>An interview with the Assistant Director of Nursing (ADON) occurred on 2/6/2025 at 2:55 PM. The ADON stated that there was not a policy for newly admitted residents that required they were to be seen by therapy prior to ambulation. She stated the nurses could make that determination based on assessment and clinical judgement. The ADON stated she was given the Concern Form for Resident #242 by the Business Office Manager on 1/30/25 and had she consulted with the DON on the phone regarding the incontinence episode and Resident #242 being upset. She indicated they decided to suspend NA #9 for poor customer service, and she had not returned to work at the facility. The ADON stated that NA #9 was very loud and that was the way she talked all the time.<br><br>An interview was completed with the Director of Nursing on 2/7/2025 at 1:30 PM. The DON stated that the nursing staff was aware that newly admitted residents did not have to be seen by therapy prior to ambulation, and that nurses could make that determination. She further stated she had not been in the facility on 1/30/2025, but that the Assistant Director of Nursing (ADON) had called her and informed her of the incident. The DON stated that she was not aware until today that Resident #242 had to urinate in the bed and that she was crying and upset over the incident. She further stated that she was told that NA #9 was loud and rude to Resident #242. The DON indicated that she had instructed the nursing staff to suspend NA #9 for poor customer service for being loud and upsetting Resident #242. She further indicated that NA #9 received disciplinary action two other times for being loud and rude.<br><br>An interview was completed with the Administrator on 2/7/2025 at 1:45 PM. The Administrator stated he was not at the facility on 1/30/2025 when Resident #242 reported the incident. He stated that the way it was explained to him, NA # 9 was just very loud and did not respond appropriately to Resident #242. The Administrator indicated that NA #9 should have gotten Resident #242 up to the bathroom instead of telling her to just go in the bed. He further indicated that NA #9 just had a very loud voice that could be interpreted by some people as yelling, but that was just how she spoke.<br><br>40044<br><br>2.) Resident #73 was admitted to the facility on [DATE].<br><br>The MDS quarterly assessment dated [DATE] revealed Resident #73 was cognitively intact. He required assistance by staff with activities of daily living (ADL).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 02/06/25 at 03:25 PM Resident #73 was alert and oriented to person, place, and time. He stated a nurse aide, name unknown, came into his room to provide care on the day he fell on [DATE]. He was seated in his wheelchair, and she stood him up, and changed his incontinence brief while he was standing up over the wheelchair and holding on to the walker placed in front of him. He stated this occurred in his room not in the bathroom. When she was done, he was trying to sit back in the wheelchair and he lost his balance and ended up landing on the floor. He stated that he did not like to be changed while standing up over the wheelchair and he especially didn't like that this occurred in his room and not in his bathroom. He stated he did not say anything to the nurse aide at the time, but he didn't like it. He stated the nurse aides had provided incontinence care to him while standing prior to this incident, and he would rather be assisted back to bed for incontinence care or taken into the bathroom for brief changes. He indicated that it was rude and insensitive to be changed while standing up over the wheelchair.<br><br>During a phone interview on 02/06/25 at 03:30 PM Nurse Aide #9 stated she provided incontinence care to Resident #73 while he was standing up over his wheelchair and holding on to his walker when he fell on [DATE]. She stated this occurred in his room and not in the bathroom. She stated he was in a private room, and indicated the room did not have a privacy curtain. She stated there was a walker in his room, and she felt she could stand him up using the walker to provide his incontinence care. She stated she placed the walker in front of his wheelchair, she assisted him to stand, she pulled off his brief and provided incontinence care. She stated she thought it was okay to provide incontinence care while he was standing up over his wheelchair. She didn't recall Resident #73 saying anything to her at the time about being changed while standing up. She stated she had done this in the past with other residents too if they could stand up. She indicated that she didn't think to take him into the bathroom or assist him back to bed to provide incontinence care to maintain his dignity. She indicated she had received training on providing incontinence care. She stated she should have assisted Resident #73 back to bed or taken him into the bathroom to provide his incontinence care.<br><br>During an interview on 02/07/25 at 4:15 PM Nurse #13 stated she was the unit charge nurse. She stated Resident #73 required staff assistance with activities of daily living (ADL). She stated Nurse Aide #9 should have assisted Resident #73 back to bed or at least taken him into the bathroom before removing his brief and providing incontinence care to maintain his dignity.<br><br>During an interview on 02/07/25 at 4:38 PM the Director of Nursing (DON) stated Nurse Aide #9 should not have provided incontinence care while Resident #73 was standing up holding on to a walker. She indicated incontinence care should be provided by staff in a dignified manner such as assisting them back to bed or taking them into the bathroom. She stated Nurse Aide #9 no longer worked for the facility and staff education would be provided. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711<br><br>Based on record review, and staff, Responsible Party (RP) and Medical Director interviews, the facility failed to communicate complete resident medical information to the receiving hospital for 1 of 1 resident reviewed for hospitalization (Resident #290).<br><br>The findings included:<br><br>Resident #290 was admitted to the facility on [DATE].<br><br>An Interact Nursing Home to hospital transfer form dated 1/18/25 was completed by Nursing Supervisor #2 on 1/28/25 at 12:17 PM. The transfer form indicated Resident #290 was a full code, vital signs were as follows: Blood pressure 110/50, respirations 22, temperature 98.0 degrees Fahrenheit, pulse 79 beats per minute and oxygen saturation 92%. The reason for transfer was resident request due to decreased urination.<br><br>Resident #290's progress notes indicated a nursing progress note dated 1/18/25 at 12:40 PM written by Nursing Supervisor #2 indicated the resident requested to be sent to the hospital because he was unable to eat or urinate. The Nurse Practitioner (NP) was notified. The NP stated that the resident was competent and to send him to the emergency room (ER) if he wanted to.<br><br>Review of an EMS report dated 1/18/25 revealed EMS arrived on the scene at 2:12 PM and departed from the facility at 2:24 PM. The staff stated Resident #290's chief complaint was he was unable to urinate.<br><br>Resident #290's progress notes indicated a nursing progress note dated 1/18/25 written by Nursing Supervisor #2 indicated the resident was sent to the hospital for evaluation at 2:20 PM.<br><br>The Emergency Provider/emergency room Note dated 1/18/25 indicated that when the resident arrived in the emergency room , he was extremely ill, hypotensive (low blood pressure), hypothermic (low temperature) and had atrial fibrillation (irregular heart rate). The nurse at the facility reported to EMS that the resident's chief complaint was dysuria (difficulty urinating). Triage vital signs at the emergency room were recorded as blood pressure 90/53, pulse 120, respirations 18, temperature 97.5. Laboratory results at the hospital indicated Clostridium Difficile specimen was positive and white blood cell count was 66.0 thousand per microliter, a critically high elevation. Resident #290 was diagnosed with Septic Shock secondary to Clostridium Difficile.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Nursing Supervisor #2 on 2/4/25 at 2:30 PM. Nursing Supervisor #2 stated she was familiar with Resident #290 and had worked with him since he was admitted . Nursing Supervisor #2 stated the resident was not eating well, did not have any appetite and seemed very tired. Nursing Supervisor #2 stated on 1/18/25, she was assigned to Resident #290 when he requested to be sent to the hospital. Nursing Supervisor #2 stated she provided the EMS personnel with a copy of the transfer form and a list of the resident's medications. Nursing Supervisor #2 stated she tried to call the hospital to provide the receiving staff with a verbal report regarding resident's condition, but her call was disconnected. Nursing Supervisor #2 stated she had to complete a medication pass and did not call the hospital back to provide the report.<br><br>An interview was conducted with Resident #290's RP on 2/5/25 at 9:20 AM indicated on the morning of 1/18/25, she received a call from Nursing Supervisor #2 who informed her she thought Resident #290 was anxious and he said he wanted to go to the hospital. The RP stated she arrived at the facility before EMS arrived to transport the resident to the hospital. The RP stated that Nursing Supervisor #2 reported to EMS that Resident #290 was probably just anxious and stated she did not think he was septic. The Nursing Supervisor did not report to EMS that the resident had loose stools.<br><br>An interview with the Medical Director on 2/7/25 at 4:30 PM revealed she expected that the nurse transferring a resident to the hospital would call the hospital and provide a complete report on the resident's condition and reason for transfer for an appropriate transfer of care.<br><br>An interview with the Director of Nursing (DON) on 2/7/25 at 4:40 PM revealed she expected the nurses to not only provide EMS with the list of medications and transfer form but also to call the hospital and provide a complete report when transferring a resident to the hospital. The DON stated the nurses were aware that this was her expectation and she did not know that Nursing Supervisor #2 had not done so. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711<br><br>Based on record review and responsible party (RP), staff, Medical Director, and Nurse Practitioner (NP) interviews, the facility failed to assess, diagnose and medically treat a resident who was presenting with signs of Clostridium Difficile (C. difficile) (According to the Centers for Disease Control and Prevention: C. difficile-is a highly contagious bacteria that causes diarrhea and inflammation of the colon, can be life-threatening and present with symptoms which include loose stools, abdominal cramping, loss of appetite and stools may have a foul odor). The facility failed to identify the seriousness of the symptoms of abdominal discomfort, frequent loose stools with foul odor, tiredness, loss of appetite, and inability to get out of bed and implement effective interventions. On [DATE] Resident #290 experienced decreased urine output and the facility failed to identify a medical emergency and failed to immediately transfer Resident #290 to the hospital on [DATE] when the nursing home received critical white blood cell count of 51.8 (normal range ,d+[DATE]). On [DATE] Resident #290 requested to be sent to the hospital because he was unable to eat or urinate. Once evaluated at the hospital on [DATE], the resident was extremely ill, hypotensive (low blood pressure), hypothermic (low temperature) and had atrial fibrillation (irregular heart rate). Vital signs at the emergency room were recorded as blood pressure ,d+[DATE] (normal ,d+[DATE]), pulse 120 (normal ,d+[DATE]), respirations 18, temperature 97.5. Laboratory results at the hospital indicated the C. diff test was positive and white blood cell count was 66.0. Resident #290 was diagnosed with septic shock (a life-threatening immune system reaction to an infection) secondary to C. Diff and passed away on [DATE]. This deficient practice was discovered for 1 of 3 residents reviewed for professional standards (Resident #290).<br><br>Immediate Jeopardy began on [DATE] when Resident #290 began experiencing loose, malodorous stools and the facility did not assess, evaluate or treat the resident. The immediate jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring of systems put in place are effective.<br><br>Findings included:<br><br>Resident #290's hospital discharge summary dated [DATE] indicated resident was admitted for a subdural hematoma (collection of blood between the brain and it's covering) due to a fall. The discharge summary indicated during the hospital stay resident underwent colonic decompression (a procedure to relieve pressure and remove gas and stool from the colon) on [DATE] and tolerated this well with excellent reduction in the colonic volume. The discharge summary indicated Resident #290 had a possible pseudo-obstruction, a condition where the colon appeared to be obstructed but there was no physical blockage.<br><br>Resident #290 was admitted on [DATE] with diagnosis of subdural hematoma.<br><br>Review of Resident #290's physician orders revealed there were no orders for laxatives or stools softeners.<br><br>Review of Resident #290's electronic bowel movement record revealed the following:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | [DATE]- One large loose stool<br><br>[DATE]- Two large stools<br><br>[DATE]- Two large stools and a medium stool<br><br>[DATE]- One large liquid stool with foul odor and one medium stool<br><br>[DATE]- Four large loose stools and two medium stools<br><br>[DATE]- One medium stool<br><br>An interview was conducted via phone with Nursing Assistant (NA) # 5 on [DATE] at 12:20 PM. NA #5 was assigned to Resident #290 on [DATE] and [DATE]. NA #5 revealed Resident #290 had loose stools continuously. NA #5 stated Resident #290 had loose stools with a foul smell. NA #5 stated she reported this to the nurse, she could recall which one, and the nurse stated okay but did not indicate what was being done about the loose stools.<br><br>Review of a NP progress note dated [DATE] indicated Resident #290's RP reported resident was having burning with urination and requested a urinalysis. Urinalysis was ordered.<br><br>Review of Resident #290's admission Minimum Data Set (MDS) dated [DATE] indicated resident was cognitively intact, was always incontinent of bowel and bladder and required moderate assistance with toileting.<br><br>Resident's care plan dated [DATE] indicated a focus of urinary incontinence. Interventions included providing incontinence care after each incontinent episode and report signs of urinary tract infection. There was not a care plan, or interventions related to bowel incontinence or loose stools.<br><br>Review of Resident #290's bowel record revealed the following:<br><br>[DATE] - One large loose liquid stool<br><br>[DATE] - One large and one medium stool<br><br>[DATE] - Three large loose stools<br><br>[DATE] - One medium and one large loose stool<br><br>[DATE] - Two large and one medium stools<br><br>[DATE] - One large loose stool<br><br>Review of a NP progress note dated [DATE] indicated resident's RP had requested a urinalysis due to painful urination. The results of the urinalysis are pending.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #290's physician orders revealed an order dated [DATE] for ciprofloxacin (an antibiotic used to treat infections including urinary tract infections) 500 milligrams (mg) twice per day by mouth for 7 days for urinary tract infection.<br><br>Review of a NP progress note dated [DATE] indicated resident's chief complaint was urinary tract infection. Resident #290's RP requested a urinalysis due to painful urination. Urinalysis was positive for infection and antibiotic was ordered.<br><br>Review of Resident #290's electronic bowel movement record revealed the following:<br><br>[DATE] - Two medium and one large loose stool<br><br>[DATE] - One large, loose stool<br><br>[DATE] - One large stool<br><br>[DATE] - One large loose stool<br><br>[DATE] - One large stool<br><br>[DATE] - Three medium stools<br><br>[DATE] - No documentation<br><br>[DATE] - One large loose liquid stool and a small stool<br><br>A nursing progress note written by Nurse #11 on [DATE] stated Resident #290 refused to get up out of bed due to diarrhea. The note did not indicate any follow-up action, assessment or notification of the Nurse Practitioner or Medical Director. There was no documented nursing assessment.<br><br>An interview was conducted with Nurse #11 on [DATE] at 2:15 PM. Nurse #11 was assigned to Resident #290 on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Nurse #11 stated Resident #290 was admitted for rehabilitation and was supposed to go home. Nurse #11 stated some days Resident #290 was too tired to participate in therapy and was weak, but she did not complete an assessment of the resident and did not think this indicated he had an infection, and she did not report this to the NP. Nurse #11 stated Resident #290 had loose stools since he was admitted , and she did not know why. Nurse #11 stated the Nursing Assistants reported to her that he had loose stools, and she reported this to the Nurse Practitioner. Nurse #11 stated she did not recall if the NP did anything about the loose stools. Nurse #11 indicated Resident #290's responsible party visited often and would apologize to her and the other staff that the resident was having so many loose, foul-smelling stools.<br><br>A physical therapy treatment encounter note dated [DATE] indicated Resident #290 refused treatment due to diarrhea. The note indicated nursing was made aware.<br><br>An occupational therapy treatment encounter note dated [DATE] indicated the therapist approached the resident for treatment twice but resident refused due to having loose bowel movements.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 3:30 PM with the Occupational Therapist (OT) who was assigned to Resident #290 on [DATE]. The OT stated Resident #290 had loose stools constantly while in the facility and it interfered with his therapy sessions due to the amount and frequency of the loose stools. Resident #290 complained during therapy of his stomach hurting at times. OT stated he informed the nurses assigned to Resident #290 that the resident was having frequent loose stools and assumed the nurses would follow up on this. The NAs were constantly having to change the resident. OT stated the former Rehabilitation Director reported to the nurses and NP about Resident #290's loose stools. Towards the end of his stay, the OT stated Resident #290 was refusing therapy, was more tired and complained of his stomach hurting. OT stated resident's condition was getting worse and worse just prior to him transferring to the hospital.<br><br>An interview was conducted with the former Rehabilitation Director via phone on [DATE] at 10:30 AM. The former Rehabilitation Director stated she worked closely with Resident #290 and was familiar with him. The former Rehabilitation Director stated Resident #290 became progressively worse during his time in the facility and was medically declining. The former Rehabilitation Director stated the therapists communicated with the nursing staff and the Nurse Practitioner frequently regarding the changes they observed in Resident #290 and the frequent loose stools. The former Rehabilitation Director stated the nurses would say they would tell the Nurse Practitioner and that the loose stools were normal and would clear up eventually. The former Rehabilitation Director stated Resident #290 complained to the therapy staff about the loose stools and not feeling well. The former Rehabilitation Director stated the NP indicated the loose stools would resolve eventually and that was not the reason the resident was here.<br><br>Review of an SBAR form (a nursing communication tool used to convey status which stands for Situation, Background, Assessment and Recommendation) indicated a change occurred on [DATE] at 3:58 PM. The form was completed by the Nursing Supervisor #3 on [DATE] at 9:51 AM. The description of the change indicated it was completed due to weight gain. It further indicated the change observed was weight loss. The Nurse Practitioner was notified of the weight change on [DATE] at 11:10 AM and no new orders were received.<br><br>Review of the weights recorded in Resident #290's electronic health record revealed the following: [DATE] 211.2 pounds (lb.), [DATE] 213.6 lb., [DATE] 209 lb.<br><br>Review of Resident #290's electronic bowel movement record revealed:<br><br>[DATE] - One medium and a large loose stool<br><br>[DATE] - No documentation<br><br>A Nurse Practitioner (NP) progress note dated [DATE] revealed Resident #290 had loose stools and was started on banana flakes for 1 week. The note did not indicate any testing was ordered regarding loose stools.<br><br>The manufacturer's information indicated banana flakes are a natural product that may be used for chronic diarrhea and may be used in conjunction with treatment for Clostridium Difficile (C. diff). The manufacturer's information further stated banana flakes are to be mixed with water or juice and administered up to 3 times per day until diarrhea is resolved.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #290's physician orders revealed an order written by the NP dated [DATE] for banana flakes one packet once per day. The order was discontinued on [DATE].<br><br>Review of Resident #290's electronic Medication Administration Record (MAR) revealed an entry for banana flakes one packet once per day with a start date of [DATE] and a discontinue date of [DATE]. Entries were signed with electronic signatures as given.<br><br>A Nurse Practitioner progress note dated [DATE] stated Resident #290 continued to have loose stools. The note indicated the resident's responsible party contacted the Gastroenterologist who recommended a Kidney Ureter and Bladder (KUB) x-ray and stool samples due to loose stools. The NP note stated the KUB was ordered, and the stool samples were to be done as an outpatient after discharge. The progress note further stated to continue banana flakes once per day. If banana flakes are ineffective will start loperamide 2 milligrams once per day as needed. (Loperamide is a non-prescription medication used to control occasional loose stools usually taken after each loose stool. Loperamide is contraindicated in C.difficile due to slowing the movement of stool through the body allowing the C.difficile toxins to build up in the colon leading to more severe colitis or inflammation of the colon).<br><br>Review of Resident #290's electronic health record revealed an order dated [DATE] to obtain a KUB. There was no order noted to obtain stool samples.<br><br>Review of Resident #290's electronic bowel movement record revealed:<br><br>[DATE] - Three large loose stools and one small stool<br><br>Review of Resident #290's electronic bowel movement record revealed:<br><br>[DATE] - One medium loose stool<br><br>[DATE] - One medium stool<br><br>[DATE] - Two large loose, liquid foul-smelling stools and a small liquid stool<br><br>Attempts were made to interview NA #2 who was assigned to Resident #290 on [DATE], [DATE] and [DATE]. Messages were left on [DATE], [DATE], [DATE] and [DATE] with no return call received.<br><br>Resident #290's electronic Medication Administration Record (MAR) indicated loperamide 2 milligrams once per day as needed with a start date of [DATE] and discontinue date of [DATE]. The electronic MAR indicated no entries were signed for loperamide as given.<br><br>Review of a nursing progress note dated [DATE] indicated the KUB test results were received and reviewed by the Nurse Practitioner with normal abdominal study results received.<br><br>A Nurse Practitioner progress note dated [DATE] indicated Resident #290 continued to have loose stools. The NP progress note indicated Resident #290 was started on banana flakes with marginal improvement. The KUB was unremarkable. Stool sample to be done outpatient following discharge. Continue banana flakes and start loperamide as needed.<br><br>An occupational therapy encounter note dated [DATE] indicated Resident #290 had increased fatigue.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #290's electronic bowel movement record revealed:<br><br>[DATE] - One large, loose stool<br><br>[DATE] - Two large loose stools<br><br>An interview was conducted with NA #8 on [DATE] at 2:22 PM. NA #8 was assigned to Resident #290 on [DATE] and [DATE]. NA #8 indicated that she was assigned to Resident #290 frequently and was familiar with his care. NA #8 stated Resident #290 had multiple loose, liquid stools during each shift. NA #8 indicated everyone knew that he was having liquid bowel movements that had a strong odor. NA #8 stated Resident #290 had liquid stools especially after he ate, and it was like everything ran right out of him. Resident #290 would ask for loperamide, and NA #8 stated she reported this to the nurse assigned to the resident, she could not recall which nurse, but she did not know if he ever received it. NA #8 stated she thought Resident #290 might have C. difficile due to the multiple liquid stools and strong odor but the nurses said it was normal for him.<br><br>A Nurse Practitioner progress note dated [DATE] revealed Resident #290 continued to have loose stools and was started on banana flakes and loperamide was ordered as needed.<br><br>Review of Resident #290's electronic bowel movement record revealed:<br><br>[DATE] - No documentation<br><br>Review of Resident #290's progress notes revealed a NP progress note dated [DATE] which indicated resident continued to have loose stools. Banana flakes were started and loperamide was ordered as needed. The KUB was unremarkable. The plan indicated continue the banana flakes and loperamide as needed.<br><br>Review of Resident #290's electronic bowel movement record revealed:<br><br>[DATE] - Two medium stools<br><br>An interview was conducted on [DATE] at 11:15 AM with NA #4 who was assigned to Resident #290 on [DATE] and [DATE]. NA #4 stated she was assigned to Resident #290 just prior to him being sent to the hospital and he was very weak. NA #4 stated she was familiar with Resident #290 and was assigned to him often and assisted other staff with him. NA #4 stated Resident #290 had very loose, frequent stools with mucus and a strange, strong odor. NA #4 indicated the nurses were aware that he had loose, frequent stools and the nurses said he was having loose stools since admission so it must be normal for him. NA #4 stated Resident #290 had about 3 loose stools per shift. On [DATE], NA #4 stated Resident #290 was not doing well and had not urinated all day which was not normal for him. NA #4 stated she reported to Nurse #11 that the resident had not urinated that day.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted with Nursing Supervisor #3 on [DATE] at 9:07 AM. Nursing Supervisor #3 stated she did not recall being informed of any problems with Resident #290's stools throughout his stay in the facility. Nursing Supervisor #3 stated she had not reviewed his bowel movement records. Nursing Supervisor #3 stated she recalled Resident #290's RP called her on [DATE] and reported that Resident #290 had complained of dizziness. Nursing Supervisor #3 stated she went and asked Resident #290 if he was dizzy and he said no. Nursing Supervisor #3 stated she did not obtain vital signs or complete a full assessment of the resident because she did not think it was significant.<br><br>A Nurse Practitioner progress note dated [DATE] indicated Resident #290 continued with loose stools. Resident #290 started on banana flakes and loperamide as needed. The KUB was unremarkable. A stool sample was to be completed outpatient after discharge. Resident with poor appetite and weakness.<br><br>Review of Resident #290's physician orders revealed an order dated [DATE] entered by the NP to perform straight catheterization (a procedure in which a hollow tube drains urine from the bladder) once and obtain laboratory tests Complete Blood Count and Comprehensive Metabolic Panel due to decreased urination.<br><br>Review of Resident #290's electronic Medication Administration Record (MAR) revealed the order for straight catheterization was electronically signed by Nurse # 11 on [DATE] at 6:30 PM. The amount of urinary output obtained was recorded as 100 milliliters.<br><br>Review of Resident #290's laboratory results dated [DATE] indicated blood specimens were collected at 2:40 PM on [DATE]. A critical panic white blood cell count level of 51.8 thousand per microliter was called to the facility at 11:48 PM. The normal value for a white blood cell count is 4XXX,d+[DATE].9 thousand per microliter.<br><br>Review of Resident #290's progress notes indicated a nursing progress note written by Nurse #6 dated [DATE] at 12:46 AM indicated the Nurse Practitioner on-call was notified of the critical laboratory value and new orders were received.<br><br>Review of Resident #290's electronic Medication Administration Record (MAR) revealed the order to place an indwelling catheter was electronically signed as completed by Nurse #6 on [DATE] at 1:30 AM.<br><br>Review of Resident #290's electronic health record revealed physician orders dated [DATE] for ceftriaxone (an antibiotic used to treat infections of the lungs, ears, skin and urinary tract) 2 grams intramuscular one-time only STAT (immediately) and hypodermoclysis (a method of administering fluids under the skin) 75 milliliters of fluid per hour continuously.<br><br>Review of Resident #290's progress notes indicated a nursing progress note written by Nurse #6 dated [DATE] at 2:47 AM which indicated hypodermoclysis was placed into the abdomen with fluids running at 75 milliliters per hour.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted via phone with Nurse #6 on [DATE] at 5:45 PM. Nurse #6 stated she was assigned to Resident #290 on [DATE] from 7:00 PM to 7:00 AM. Nurse #6 stated Resident #290 was very sick that night. Nurse #6 did not indicate that she assessed Resident #290 for specific symptoms, just stated that he appeared to not be feeling well. When she received the critical high lab results, she called the on-call provider. The on-call provider did not say to send the resident to the hospital and Nurse #6 stated she did not ask the on-call provider if she should send the resident to the hospital. Nurse #6 could not recall if she reported to the on-call provider that Resident #290 was designated as a Full Code status. Nurse #6 stated the on-call provider gave orders to administer an antibiotic, insert an indwelling catheter and administer fluids. Nurse #6 stated she inserted the catheter and Resident #290 did not have any urinary output from the indwelling catheter. Nurse #6 stated she did not call the on-call provider back to report the lack of urinary output and did not assess the resident for further symptoms, but she tried to encourage the resident to drink fluids throughout the night. Nurse #6 stated she did not recall if Resident #290 had loose stools that night, but she recalled he had loose stools throughout his stay at the facility.<br><br>An interview was conducted on [DATE] at 2:20 PM with Nursing Assistant (NA) #3. NA #3 was assigned to Resident #290 on [DATE] from 7:00 AM to 3:00 PM. NA #3 stated she was familiar with Resident #290 and was assigned to him several times including the day he was sent to the hospital. NA #3 stated Resident #290 was having loose, runny stools all the time while he was in the facility. NA #3 stated she did not recall a foul odor. NA #3 stated she did not report the loose stools to the nurse since she assumed the nurses were already aware.<br><br>Review of an Interact Nursing Home to hospital transfer form dated [DATE] completed by Nursing Supervisor #2 on [DATE] at 12:17 PM indicated Resident #290 was a full code, vital signs were as follows: Blood pressure ,d+[DATE], temperature 97, respirations 22, temperature 98.3 and oxygen saturation 92%. The reason for transfer was the resident requested transfer due to decreased urination.<br><br>Review of Resident #290's progress notes indicated a nursing progress note dated [DATE] written by Nursing Supervisor #2 at 12:40 PM which indicated the resident requested to be sent to the hospital because he was unable to eat or urinate. The Nurse Practitioner was notified. The note indicated the Nurse Practitioner stated the resident was competent and to send him to the emergency room if that was what he wanted.<br><br>Review of Resident #290's progress notes indicated a nursing progress note dated [DATE] at 2:31 written by Nursing Supervisor #2 indicated the resident was sent to the hospital for evaluation at 2:20 PM.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted with the Nursing Supervisor #2 on [DATE] at 2:30 PM. Nursing Supervisor #2 stated she was familiar with Resident #290 and had worked with him since he was admitted . Nursing Supervisor #2 stated Resident #290 frequently had loose stools throughout his stay and she thought it was normal for the resident. She stated she had not reported the loose stools to the Nurse Practitioner or the Physician. Nursing Supervisor #2 stated he had banana flakes ordered that were supposed to help with the loose stools. Nursing Supervisor #2 stated the resident was not eating well, did not have any appetite and seemed very tired but she did not report these findings and did not think these were signs of infection or sepsis. Nursing Supervisor #2 stated she had not noticed a foul odor from his stools and it was not reported to her by staff. Normally if there was a resident having loose stools or stools with a foul odor it was reported to the provider for further orders. Nursing Supervisor #2 stated she recalled that Resident #290's family had received an order from the Gastroenterologist for some type of stool sample to be obtained but she did not think it had been collected or sent out. Nursing Supervisor #2 stated on [DATE], she was assigned to Resident #290, and he requested to be sent to the hospital. Nursing Supervisor #2 stated Resident #290 appeared very tired, but she did not recall anything abnormal about his condition at the time and did not think that being tired was a sign of infection or sepsis. Nursing Supervisor #2 stated she did not review Resident #290's bowel movement records prior to his transfer to the hospital and did not have a record of his urinary output.<br><br>Review of an Emergency Medical Services (EMS) report dated [DATE] revealed EMS arrived on the scene at 2:12 PM and departed from the facility at 2:24 PM. The EMS narrative indicated the staff stated the reason for transport was Resident #290 was unable to urinate for 2 days. Staff reported straight catheterization was attempted. Staff reported possible infection but denied sepsis diagnosis or symptoms. When assessed by EMS the resident complained of weakness and being very tired. EMS noted the resident was having a hard time staying awake, was slow to respond to questions and complained of nausea. Intravenous access was attempted 3 times unsuccessfully. Vital signs obtained during transport to the hospital were as follows:<br><br>2:28 PM Blood pressure ,d+[DATE] Pulse 73 Respirations 16 Oxygen saturation 95%<br><br>2:35 PM Blood pressure ,d+[DATE], Pulse 20, Respirations and Oxygen saturation not recorded<br><br>2:50 PM Blood pressure ,d+[DATE], Pulse 45, Respirations 16, Oxygen saturation 94<br><br>2:52 PM Blood pressure ,d+[DATE], Pulse 65, Respirations 16, Oxygen saturation not recorded.<br><br>Attempt was made on [DATE] at 2:00 PM to interview via phone the EMS personnel that responded to the call to transport Resident #290 to the hospital. A message was left with no return call.<br><br>The Emergency Provider emergency room Note dated [DATE] indicated the resident arrived in the emergency room and was extremely ill, hypotensive (low blood pressure), hypothermic (low temperature) and had atrial fibrillation (irregular heart rate). Triage vital signs at the emergency room were recorded as blood pressure ,d+[DATE], pulse 120, respirations 18, temperature 97.5. Laboratory results at the hospital indicated the C. diff test was positive and white blood cell count was 66.0. Resident #290 was diagnosed with Septic Shock secondary to C. Diff.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The hospital discharge summary dated [DATE] indicated Resident #290 was admitted on [DATE] with admitting diagnosis of septic shock secondary to C. difficile colitis. Resident #290 presented with a chief complaint of persistent diarrhea and dehydration with approximately 1 month of persistent malodorous diarrhea and dehydration. In the emergency department, the resident's blood pressure was ,d+[DATE] and pulse was 110. [NAME] blood count was 66 and resident tested positive for C. difficile. The resident was admitted to the intensive care unit. Resident's condition declined. Resident #290 deceased on [DATE] at 11:02 PM.<br><br>Review of Resident #290's death certificate dated [DATE] indicated resident's cause of death was Sepsis, C. Diff and acute kidney injury.<br><br>Review of the electronic medical record revealed no documentation in the nursing progress notes regarding Resident #290's loose stools during the duration of his stay at the facility. There was also no discovered mention of a family member or therapy staff expressing concern about the Resident #290's loose stools.<br><br>An interview was conducted on [DATE] at 2:10 PM with the Evening Nursing Supervisor who stated Resident #290 had loose stools all the time since he was admitted , and she assumed this was normal for him. The Evening Nursing Supervisor stated she did not recall anyone reporting anything about resident's stools having a foul odor. The Evening Supervisor stated she had not reported the loose stools to the provider because she thought this was the baseline for him and she had not assessed him for any other symptoms.<br><br>A telephone interview was conducted with Resident #290's RP on [DATE] at 9:20 AM. The RP stated she visited Resident #290 daily and sometimes twice per day indicated she observed Resident #290 had frequent loose stools that were malodorous, and the odor was noticeable in the hallway. The RP stated Resident #290 indicated he could not tell when he was urinating or having a bowel movement, that the stools were liquid and would just run out of him. The RP stated she had observed him with liquid feces running down his legs and stated she reported to the nurses' multiple times about the loose stools. The RP stated she talked to the NP frequently and reported to him the loose stools. The RP stated she called the Gastroenterologist to report the loose stools since the NP had not addressed it. The RP stated she reported to the Nursing Assistant on admission that resident had frequent bowel movements but not that he normally had loose stools. She further stated she informed the staff he had a procedure on his bowel in the hospital, but his bowel movements had returned to normal. The RP stated she was not asked by the nursing staff or the NP about C. diff and the resident did not have history of C. difficile or other bowel issues. The RP stated Resident #290 had a loss of appetite, nausea and stomach pain in the weeks before he went to the hospital. The RP indicated just prior to going to the hospital, the Nursing Assistant stated Resident #290 was not acting right and she observed this also. The RP reported this to Nurse #11 who asked her what she wanted done about it. The RP indicated on the morning of [DATE], she received a call from Nursing Supervisor #2 who informed her she thought Resident #290 was having anxiety and he requested to go to the hospital. The RP stated she arrived at the facility before the resident left via EMS to go to the hospital and indicated she observed the resident struggling to breathe and he stated he had an infection and knew something was wrong. EMS arrived and Nursing Supervisor #2 reported to EMS that Resident #290 was probably just anxious and stated she did not think he was septic. Nursing Supervisor #2 did not report to EMS that resident had loose stools.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview conducted with the Nurse Practitioner on [DATE] at 3:00 PM revealed he was aware Resident #290 had constant loose stools during his stay in the facility and that this was a sign of C. Diff. The Nurse Practitioner stated Resident #290 was admitted for rehabilitation following a subdural hematoma and that was his focus. The NP stated Resident #290 had discharge plans during his stay so he thought the issue of loose stools would be addressed as an outpatient following discharge. The NP stated he ordered the Kidney Ureter and Bladder (KUB) x-ray after the family member consulted with the Gastroenterologist. The result of the KUB x-ray was normal. The NP stated he ordered banana flakes, but Resident #290 still could have had C. Diff. The NP stated he did not investigate why the resident was having loose stools or if he had any history of gastrointestinal issues. The NP stated continuous loose stools did not seem like a problem at the time, but in hindsight maybe he should have done something else. The NP stated he did not recall the Occupational or Physical Therapists or the Rehabilitation Director reporting that Resident #290 was weak, having diarrhea or not feeling well.<br><br>A follow up interview was conducted with the Nurse Practitioner on [DATE] at 1:00 PM to obtain clarification of Resident 290's condition and the course of treatment. The Nurse Practitioner stated if he had known the resident had loose foul-smelling stools, he might have ordered a test for C. difficile. The Nurse Practitioner stated he talked to Resident #290's RP a couple of times during the resident's stay, but did not recall her having any concerns. The Nurse Practitioner stated the resident never really complained about anything, so he was not concerned. The Nurse Practitioner stated he was not notified of loose stools since admission. The NP stated if the resident was having loose stools more than 1 per day he would have expected t [TRUNCATED] |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173<br><br>Based on observations, record review, and staff, resident, and Medical Director interviews, the facility failed to have an effective system in place for communicating a therapy order for a left hand splint to nursing staff for 1 of 1 resident (Resident #71) reviewed for a contracture and limited range of motion.<br><br>Findings included:<br><br>Resident #71 was admitted to the facility on [DATE]. Diagnosis included stroke with left side weakness, difficulty in walking, and muscle weakness. There was no diagnosis for contractures.<br><br>A physician's order was written on 05/22/2024 to evaluate and treat as needed for Physical Therapy and Occupational Therapy.<br><br>Review of an Occupational Therapy note entered by Occupational Therapist (OT) #1 and dated 07/23/24 revealed splint / orthotic recommendations were none at this time. The note indicated OT #1 would continue to assess. The assessment revealed the following questions: Does resident present with contracture (s)? = Yes; Do impairments affect functional skills? = Yes. The note indicated OT #1 would continue to assess. The musculoskeletal assessment revealed the Range of Motion (ROM) and strength of the right upper extremity were within normal limits. Range of motion to left upper extremity (shoulder) was impaired, left elbow / forearm impaired; and left hand and wrist were impaired.<br><br>The discharge summary note written by OT #1 dated 11/22/24 revealed on 09/19/24 a request for a splint was sent. On 11/18/24 the note indicated awaiting arrival as splint was on back order from initial supplier. The note stated OT #1 ordered the splint through a different supplier.<br><br>The summary of skilled services note by OT #1 dated 11/20/24 revealed OT #1 provided moist hot pack to left hand to decrease pain and stiffness and traced left hand and molded Resident #71's hand splint to promote extension of digits and abduction of thumb in order to decrease risk of contractures. OT #1 refined the splint in order to maximize comfort and decrease risk of skin breakdown. OT #1's note indicated under additional skilled service: Instruction on care of splint and wear schedule and that resident was exhibiting pain.<br><br>A treatment encounter note written by OT #1 dated 11/22/24 at 4:00 PM revealed in part resident and caregiver training: instructed resident and primary caregivers in the use of adaptive equipment and compensatory strategies in order to facilitate improved functional abilities with variable carryover demonstrated by caregivers.<br><br>On the discharge summary note written by OT #1 dated 11/22/24, the note stated Resident #71 had a resting hand splint and could tolerate wearing with staff knowledgeable of splint wear (frequency of time the resident should wear the splint) as well as Resident #71.<br><br>Occupation Therapist #1 no longer worked at the facility and could not be reached for an interview.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #71 was cognitively intact and demonstrated no behaviors. Resident #71 required set up with one staff physical assistance with eating, dependent with one staff physical assistance with toileting, substantial assistance with one staff physical assistance with showering, dressing, and transfers, and set up with one staff physical assistance with personal hygiene. The assessment indicated Resident #71 had received occupational therapy from 07/23/24 through 11/22/24, and the resident was receiving restorative nursing for transfers but none for splint or brace assistance.<br><br>A review of Resident #71's care plan updated on 11/24/24 revealed a plan of care for left hemiplegia (paralysis to one side of the body) and hemiparesis (weakness to one side of the body) related to a stroke (a result of poor blood flow to the brain). There was no care plan for range of motion or the use of splints.<br><br>Review of the physician orders since 11/22/24 through 02/07/25 revealed there were no orders in place to apply a left hand splint for Resident #71.<br><br>Review of the Medication Administration Record (MAR) from 11/22/24 through 02/07/25 revealed there were no orders for nursing staff to sign off that a left hand splint for Resident #71 was applied.<br><br>An interview with Resident #71 on 02/03/25 at 11:30 AM revealed he had been working with therapy in the past and the Occupational Therapist told him she was going to order a splint for his left hand. Resident #71 stated the OT had made him a splint because the one she ordered was on back order. Resident #71 stated he had not seen the splint for some time and the staff have not inquired as to where it was and why it was not on him. He stated he has not seen the splint in weeks. Resident #71 stated he would wear the splint if it were applied.<br><br>An observation of Resident #71 on 02/03/25 at 11:30 AM, 2:20 PM, 3:18 PM, and 4:30 PM revealed there was no left hand splint applied. There was no splint in view in his room at any of these times. Resident #71's hand was noted to be contracted. His fist was closed and he demonstrated difficulty when trying to open his hand and extend his fingers.<br><br>An observation of Resident #71 on 02/05/225 at 10:07 AM, 12:30 PM and 2:45 PM and 4:10 PM revealed there was no left hand splint applied. There was no splint in view in his room at any of these times.<br><br>An observation of Resident #71 on 02/06/25 at 9:30 AM, 1:17 PM and 4:38 PM revealed there was no left hand splint applied. There was no splint in view in his room at any of these times.<br><br>An interview was conducted with Nurse Aide (NA) #8 on 02/06/25 at 2:42 PM revealed she was aware Resident #71 had a splint for his left hand. NA #8 stated whenever she was assigned to Resident #71 she would apply the splint. NA #8 stated she was not aware that the splint was missing or that it needed repair, but she had not worked with Resident #71 this week. NA #8 stated she could not recall the last time she was assigned to Resident #71.<br><br>A follow up interview was conducted with Resident #71 on 02/07/25 at 9:00 AM. Resident #71 reported he had a splint for his left hand but he has not had it on because no one could find it. He reported that if the staff could find it and offer to put it on him, he would wear it. Resident #71 stated he has told nursing staff that he needed his splint applied and that he could not find it.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with NA #1 on 02/07/25 at 9:45 AM. NA #1 revealed she worked on Fridays and was familiar with Resident #71. She stated she did not recall him having a splint and if he had one she would have applied it. NA #1 stated Resident #71 had never asked her to apply a splint. NA #1 assisted in looking for the splint in Resident #71's room and it was noted to be located on the top shelf of his closet in visible site. The splint was removed from the closet and NA #1 asked Resident #71 if he would like to wear it. He stated yes. NA #1 attempted to apply the splint, but the splint was noted to have been missing a Velcro band to secure the splint to his hand. The splint was then removed by NA #1 and she stated she would have therapy look at it. Resident #71 stated he had never asked NA #1 to apply the splint in the past, but he had asked other nursing staff.<br><br>An interview was conducted with Occupational Therapist (OT) #2 on 02/07/25 at 10:20 AM. OT #2 stated she was asked to evaluate Resident #71 on 02/06/25 by Resident #1's family member and Resident #71 because he would like to be discharged home. OT #2 stated she had been working at the facility for a month and was not aware of any splints for Resident #71, but she would look into it. During this interview, the Evening Supervisor arrived and provided the left hand splint to OT #2 for Resident #71 and stated that it needed to be repaired. At this time, the Evening Supervisor stated Resident #71 had it on yesterday 02/06/25 but it broke and now it needed to be repaired. The Evening Supervisor was made aware that the splint, according to the resident, was missing for and had not been applied in a long time.<br><br>An interview with Nurse #5 on 02/07/25 at 3:10 PM revealed that he thought the resident wore a splint on occasion but he was not aware that it was a requirement. Nurse #5 stated there were no orders in the electronic record to apply a left hand splint and he was never in serviced by the therapy department on how to utilize the left hand splint or how often Resident #71 was supposed to wear the splint for his left hand contracture. Nurse #5 stated he did not recall if Resident #71 ever asked him to apply his left hand splint.<br><br>An interview was conducted with Nurse #4 on 02/07/25 at 3:10 PM. Nurse #4 reported she had no knowledge of Resident #71 ever wearing a splint. She stated she never saw a splint in his room nor had he ever mentioned that he needed to wear his splint for his left hand contracture. Nurse #4 stated she had never been given any education on how to apply the left hand splint by therapy and there was no order to apply the splint in the electronic record.<br><br>An interview was conducted with the interim Therapy Rehab Director on 02/07/25 at 3:30 PM. The Rehab Director provided documentation to support that OT #1 made Resident #71 a splint on 11/20/24. The Rehab Director confirmed OT #1's note stated that instruction on care of the splint and a wear schedule (frequency of how often the splint should be worn) was indicated on the treatment encounter note dated 11/22/24. The Rehab Director stated OT #1 should have educated the staff regarding the splint and the schedule and frequency of when the splint should be applied. Furthermore, she added, OT #1 should have implemented an order in the electronic record so that it would become a nursing measure. She stated once the order was entered with the wear schedule, it would trigger to the Medication Administration Record so that the nurses would know Resident #71 needed to have the splint applied and for how long. The Rehab Director stated OT #1 made the splint for Resident #71 in order to maintain range of motion and to prevent the left hand from getting more contracted. The Rehab Director stated that OT #1 should have followed through with her recommendation for the splint application and communicated the recommendation to the nursing staff to ensure the left hand splint was getting applied.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the Director of Nursing (DON) on 02/07/25 at 5:30 PM revealed she had no knowledge of Resident #71 requiring a splint for his left hand contracture. The DON stated if she had known by OT #1 that he required a splint, she would have made sure the order was put in the electronic record so that it would trigger to the medication administration record to let nurses know it needed to be applied and she would have made sure it went into the Resident #71's profile so that nurse aides would know as well.<br><br>An interview was conducted via phone with the Medical Director on 02/10/25 at 4:50 PM. The Medical Director stated she would have expected the therapist to follow through with her recommendation and communicate clear orders and instructions so the order could be implemented. The Medical Director stated not having the splint would put Resident #71 at further risk for his contracture to worsen. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044<br><br>Based on observations, record review, and resident and staff interviews, the facility failed to provide care in a safe manner during the provision of incontinence care resulting in the resident being lowered to the floor. This occurred for 1 of 3 residents reviewed for falls (Resident #73).<br><br>Findings included.<br><br>Resident #73 was admitted to the facility on [DATE] with diagnoses including muscle weakness and a history of falls with femur fracture.<br><br>A care plan updated 12/02/24 revealed Resident #73 was at risk for falls, had a decline in his functional abilities, and self-care due to a history of falls with right femur fracture. Interventions included in part to use two-person assistance for all transfers.<br><br>The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #73 was cognitively intact. He had no falls at the time of assessment. His weight was 210 pounds.<br><br>An incident report dated 01/30/25 at 2:30 PM completed by Nurse #5 revealed Resident #73 fell while being assisted by the nurse aide. He had no injuries and no complaints of pain. Resident #73 was alert and responded appropriately.<br><br>During an interview on 02/06/25 at 3:25 PM Resident #73 was alert and oriented to person, place, and time. He stated the nurse aide, name unknown, came into his room to provide care on 01/30/25. He was seated in his wheelchair, and she stood him up, and changed his incontinence brief while he was standing up over the wheelchair and holding on to the walker placed in front of him. He stated the incident occurred in his room not in the bathroom. When she was done, he was trying to sit back in the wheelchair and he lost his balance and ended up landing on the floor. He stated he had no injuries from the fall. He reported there was only one nurse aide in the room with him during that incident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 02/06/25 at 3:30 PM Nurse Aide #9 stated she was the nurse aide involved in the fall incident with Resident #73. She stated she had not worked with Resident #73 in over a month and when she last provided care to him, he used the sit to stand lift for transfers. She stated he had improved and there was a walker in his room, and she felt she could stand him up using the walker without the assistance of a second person. She stated she went in alone to do his incontinence care, and she did not ask another staff member for assistance to transfer him to a standing position. She did not use the gait belt to assist him while standing him up and she did not have a gait belt with her. She stated she placed the walker in front of his wheelchair, she assisted him to stand, she pulled off his brief and provided incontinence care while he was standing up over the wheelchair and holding on to the walker. She stated when she was done, she attempted to sit him back down in the wheelchair and he leaned to his right side, and she could not get him back in the wheelchair, so she lowered him to the floor. After she lowered him to the floor, she left the room to get Nurse #5. She and Nurse #5 transferred Resident #73 to the bed using the mechanical lift following the fall. She stated she thought it was okay to provide incontinence care while he was standing up. She stated she looked at his care plan prior to transferring him and it showed that he needed limited assistance.<br><br>During an interview on 02/07/25 at 4:00 PM Nurse #5 stated Nurse Aide #9 notified him of the fall. He went in and assessed Resident #73 and there were no injuries. He stated he and Nurse Aide #9 transferred Resident #73 to bed using the mechanical lift. He indicated that Resident #73 required two-person assistance with all transfers.<br><br>During an interview on 02/07/25 at 4:15 PM Nurse #13 stated she was the unit charge nurse. She stated Resident #73 has required two-person assistance with transfers since he was admitted in May 2024. She indicated he weighed over 200 pounds and was six feet tall. She stated staff were to review the care plan to determine transfer needs and Resident #73's care plan did show that he required two-person assistance with all transfers.<br><br>During an interview on 02/07/25 at 4:38 PM the Director of Nursing (DON) stated Resident #73 required two-person assistance with all transfers. She stated Nurse Aide #9 should have asked another staff member for assistance before standing him up. She indicated she should not have provided incontinence care to a resident with weakness and a history of falls while he was standing up holding on to a walker. She stated Nurse Aide #9 no longer worked for the facility and staff education would be provided. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173<br><br>Based on observations, record review, and staff and Medical Director interviews, the facility failed to maintain a resident's indwelling urinary catheter below the resident's bladder when the Wound Treatment Nurse placed the indwelling urinary catheter on the resident's bed during a sacral pressure ulcer dressing change and failed to cleanse the urethral meatus and catheter tubing during catheter care in a manner to prevent contamination/infection for 1 of 1 resident observed for urinary catheters (Resident #66).<br><br>Findings included:<br><br>Resident #66 was admitted to the facility on [DATE]. Diagnoses included neuromuscular dysfunction of bladder.<br><br>Review of Resident #66's care plan revealed a plan of care updated on 05/20/24 for an indwelling urinary catheter related to neurogenic bladder. The goal of care included Resident #66 will be free from catheter related complications with interventions to include monitor for discomfort, blood in the urine, cloudy urine, foul smelling urine, and change in mental status, administer peri care (cleaning of genital areas) per protocol, maintain urinary drainage bag below the bladder level, and monitor peri-area for redness, irritation and skin excoriation/breakdown.<br><br>The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #66 was cognitively intact. He was dependent with one staff physical assistance for bed mobility and activities of daily living (ADL) with impairment to both upper and lower extremities. Resident #66 had an indwelling urinary catheter and was always incontinent of bowel. Resident #66 had an unstageable pressure ulcer.<br><br>A physician's order written on 12/03/24 revealed indwelling urinary catheter to drainage related to neurogenic bladder.<br><br>a. An observation of wound care for Resident #66 was conducted on 02/05/25 at 9:30 AM with the Wound Treatment Nurse. Resident #66 was noted to have an indwelling urinary catheter inserted with a urinary drainage bag hanging below his bladder on the right side of the bed with approximately 400 milliliters of urine in the drainage bag. The tubing was not kinked and the stat lock (a device that secures a catheter in place to prevent movement and accidental removal) was in place on resident's right upper thigh. Prior to starting the wound treatment, the Wound Treatment Nurse removed the catheter from the lower right side of the bed and placed it on top of the resident's bed by the resident's feet. The indwelling catheter was level with the resident's bladder during the sacral pressure ulcer dressing change while Resident #66 was lying on his right side. Resident #66 was awake and alert and had no complaints of pain or discomfort.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Wound Treatment Nurse on 02/05/25 at 10:05 AM. The Wound Treatment Nurse stated she placed the catheter drainage bag on top of the resident's bed by the resident's feet to prevent it from kinking or twisting. The Wound Treatment Nurse stated the resident was lying on his right side and the catheter drainage bag was on his right side so she should have left the drainage bag positioned lower than his bladder while she was doing the dressing change since it was not kinked or at risk for getting occluded.<br><br>An interview with the Director of Nursing (DON) on 02/07/25 at 5:00 PM was conducted. The DON stated the Wound Treatment Nurse should not have placed the catheter drainage bag on the bed while doing the pressure ulcer treatment and the catheter drainage bag should always be positioned below the bladder to prevent the urine from back flowing into the bladder which could potentially cause an infection.<br><br>A phone interview with the Medical Director on 02/10/25 at 4:35 PM revealed there was no reason to put the urinary drainage bag on the bed and the drainage bag should always be lower than the bladder to prevent the back flow of urine into the bladder and prevent the risk of infection.<br><br>b. An observation of catheter care was conducted with Nurse Aide (NA) #3 for Resident #66 on 02/05/25 at 10:15 AM. NA #3 proceeded to the bathroom and was noted to turn on the hot water valve to wet a wash cloth. NA #3 did not apply any soap to the wash cloth. NA #3 proceeded to take down Resident #66's brief and with one end of the wash cloth she started below the catheter tubing where it exited the urethra (tube that connects the urinary bladder to the urinary meatus) and pulled the wash cloth downwards, she then turned the wash cloth around to a clean area on the cloth and, again, started below the catheter tubing where it exited the urethra and pulled the wash cloth downwards and then she did it a third time with another end of the same cloth starting, again, below the catheter tubing where it exited the urethra. NA #3 did not pull back the urethral meatus (the opening of the urethra through which urine exits the body) and clean around the penis at any time.<br><br>An interview was conducted with NA #3 on 02/05/25 at 10:20 AM. She reported she was trained on how to clean the catheter and she should have used warm soapy water and pulled back the meatus and thoroughly cleaned the penis. Furthermore, she stated she should have cleansed the entire tubing and should not have started below the insertion site, but at the insertion site. NA #3 stated she did not know why she did not clean the catheter as she was taught.<br><br>An interview was conducted with the Director of Nursing (DON) on 02/07/25 at 5:00 PM. The DON stated NA #3 had been provided in service and education upon hire and yearly in the facility's skills fair on the proper way to clean a male residents' catheter. The DON provided the catheter care protocol that the facility used and per the instruction, NA #3 should have pulled the urethral meatus back and cleansed the area with warm soapy water and she should have cleansed the entire tubing from insertion site downward with a warm soapy cloth when she was cleaning the tubing. The DON stated cleansing the tubing and the urethral meatus helps prevent the resident from a potential infection.<br><br>A phone interview with the Medical Director on 02/10/25 at 4:35 PM revealed she would have expected the nursing staff to be aware of the proper way to provide catheter care in order to prevent infection. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0714<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure the physician properly assigns and delegates tasks to a physician assistant, nurse practitioner or clinical nurse specialist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711<br><br>Based on record review and interviews with staff, the resident's Responsible Party (RP), Medical Director, and Nurse Practitioner (NP), the NP failed to communicate and collaborate with the Medical Director for a resident (Resident #290) who was presenting with signs of Clostridium Difficile (C. difficile or C. diff) According to the Centers for Disease Control and Prevention: C. diff-is a highly contagious bacteria that causes diarrhea and inflammation of the colon, can be life-threatening and present with symptoms which include loose stools, abdominal cramping, loss of appetite and stools may have a foul odor. For the period of [DATE], date of admission, through [DATE], the first date the NP had a progress note for Resident #290, the resident was recorded as having 42 stools in 24 days. Resident #290 was documented as having loose stools during each of the 6 progress notes the NP had for the resident, starting with the progress note dated [DATE], through the last progress note on [DATE]. For the period of [DATE] through [DATE] Resident #290 was recorded as having 15 stools in 8 days. From the [DATE] progress note through the date Resident #290 was discharged to the hospital, the NP did not consult with the Medical Director despite the resident's documented persistent and foul-smelling loose stools. Due to the resident's continued loose stools, and foul odor of the stools, the resident's RP reached out to a Gastroenterologist and received a recommendation for a stool sample to be sent in for analysis. Without consultation with the Medical Director, the NP elected to postpone obtaining and submitting the stool sample until after the resident's discharge. On [DATE] Resident #290 requested to be transferred to the hospital where he tested positive for C. diff, was diagnosed with septic shock secondary to C. diff and died in the hospital on [DATE]. The death certificate indicated the cause of death was septic shock secondary to C. diff and acute kidney injury. This occurred for 1 of 1 resident reviewed for coordination of care.<br><br>Immediate jeopardy began on [DATE] when the NP failed to communicate and collaborate with the Medical Director regarding his knowledge of Resident #290's repeated loose and foul-smelling stools. The immediate jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place are effective.<br><br>The findings included:<br><br>Review of the facility's Medical Director Agreement effective [DATE], indicated the Medical Director develops and periodically reviews and revises, as indicated, policies that govern practitioners in the facility other than physicians, including physician assistants and nurse practitioners; and guides the facility regarding clinical decision making and the provision of direct care.<br><br>Review of the facility's Medical Director job description revealed the expectation the medical director provides guidance and oversight of the other providers in the facility. The Medical Director is available to assist providers to answer clinical questions regarding the residents to ensure that the resident-centered standard of practice is maintained.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0714<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #290's hospital discharge summary dated [DATE] indicated Resident #290 was admitted with a subdural hematoma. During the hospital stay, the resident underwent decompression of the colon (a procedure to reduce gas and feces in the colon) on [DATE] and tolerated the procedure well with reduction in the colon volume.<br><br>Resident #290 was admitted to the facility on [DATE] with diagnosis of subdural hematoma.<br><br>For the time period of [DATE] through [DATE] Resident #290 had a total of 42 stools documented with 12 of the 42 that were loose or liquid with one (1) that was described as having a foul odor according to the bowel movement records.<br><br>The NP progress note dated [DATE] revealed Resident #290 was seen for a chief complaint of loose stools and was started on banana flakes (a medication to help with loose stools) for 1 week. The note did not include an assessment of Resident #290's abdomen or bowel sounds. The progress note gave no indication that the NP communicated the resident's condition to the Medical Director.<br><br>Review of Resident #290's physician orders revealed an order written by the NP dated [DATE] for banana flakes one packet once per day. The order was discontinued on [DATE].<br><br>Review of Resident #290's electronic Medication Administration Record (MAR) revealed an entry for banana flakes one packet once per day with a start date of [DATE] and a discontinue date of [DATE]. All entries were signed with electronic signatures as given.<br><br>For the date of [DATE] the Resident #290 had 3 large loose stools and a small stool according to the bowel movement record for Resident #290.<br><br>The NP progress note dated [DATE] stated the nature of presenting problem was discharge to home. The note indicated Resident #290 continued to have loose stools. Resident #290's responsible party contacted the Gastroenterologist who recommended a Kidney Ureter and Bladder (KUB) x ray and a stool sample panel due to loose stools. The NP progress note stated the KUB was ordered, and the stool samples would be done outpatient after discharge. The progress note further stated to continue the banana flakes and if the banana flakes were ineffective would start loperamide (an anti-diarrheal medication) 2 milligrams once per day as needed. The progress note gave no indication the NP communicated the resident's condition to the Medical Director, nor did he consult the Gastroenterologist.<br><br>Review of Resident #290's electronic health record revealed an order dated [DATE] to obtain a KUB. There was no order noted to obtain stool samples.<br><br>For the time period of [DATE] through [DATE] Resident #290 had 5 stools total recorded with two described as loose and foul-smelling according to the bowel movement record for Resident #290.<br><br>The NP progress note dated [DATE] indicated Resident #290 continued to have loose stools. Banana flakes were ordered with marginal improvement. KUB was unremarkable. The resident will have stool samples done outpatient following discharge. Continue banana flakes and start loperamide as needed. The progress note gave no indication that the NP communicated the resident's condition to the Medical Director, nor did he consult with the Gastroenterologist.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0714<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #290's electronic Medication Administration Record (MAR) indicated loperamide 2 milligrams once per day as needed was ordered on [DATE]. The electronic MAR indicated no entries were signed for loperamide indicating loperamide was not administered.<br><br>For the time period from [DATE] through [DATE] Resident #290 had 3 large loose stools according to the bowel movement record for Resident #290.<br><br>The NP progress note dated [DATE] indicated the chief complaint was loose stools. The note indicated Resident #290 continued to have loose stools and was started on banana flakes and loperamide as needed. The progress note gave no indication that the NP communicated the resident's continued loose stools with the use of banana flakes to the Medical Director. The progress note gave no indication that the bowel movement records were evaluated to determine the effectiveness of the banana flakes.<br><br>The NP progress note dated [DATE] indicated Resident #290's chief complaint was loose stools. The note indicated the resident continued to have loose stools. The note provided no indication that Resident #290's bowel movement records were reviewed. The plan indicated the KUB was unremarkable, to continue the banana flakes and continue loperamide as needed. The progress note gave no indication that the NP communicated the resident's condition to the Medical Director.<br><br>A Nurse Practitioner progress note dated [DATE] indicated Resident #290 continued with loose stools, had poor appetite and weakness. Banana flakes and loperamide were ordered, the KUB was unremarkable, and a stool sample would be completed as an outpatient after discharge. The progress note gave no indication that the NP communicated the resident's condition to the Medical Director.<br><br>Review of Resident #290's physician orders revealed an order dated [DATE] entered by the NP to for a nurse at the facility to perform a urinary straight catheterization (a procedure in which a temporary catheter is used to drain urine from the bladder and then the catheter is immediately removed once the bladder is emptied) once and obtain the following laboratory tests; Complete Blood Count and Comprehensive Metabolic Panel due to decreased urination.<br><br>Review of Resident #290's electronic Medication Administration Record (MAR) revealed the order for straight catheterization was electronically signed by Nurse #11 on [DATE] at 6:30 PM. The amount of urinary output obtained was recorded as 100 milliliters.<br><br>For the time period from [DATE] to [DATE], Resident #290 had 1 large and 2 medium stools recorded according to the bowel movement record for Resident #290.<br><br>Review of Resident #290's laboratory results dated [DATE] indicated a high panic level white blood cell (part of the body's immune system to fight infection) count (WBC) of 51.3 thousand per microliter (a normal WBC would be between 4.5 thousand and 11.0 thousand per microliter) was reported to the facility at 11:48 PM. The lab report was not signed off by the nurse as reviewed or communicated, nor was it signed off as reviewed by the NP, and it was not signed off as communicated to the MD by the NP.<br><br>Review of Resident #290's progress notes indicated a nursing progress note dated [DATE] (Saturday) at 12:46 AM the Nurse Practitioner on-call (not Resident #290's NP) was notified of a high panic laboratory value and new orders were received. The progress note did not document the NP had reported the panic labs to the facility Medical Director.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0714<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #290's electronic health record revealed physician orders dated [DATE] for ceftriaxone (an antibiotic) 2 grams intramuscular one-time only STAT (as soon as possible), hypodermoclysis (a method of administering fluids under the skin) 75 milliliters of fluid per hour to run continuously with no total amount specified and no time or date to stop the infusion and insert an indwelling urinary catheter.<br><br>Review of Resident #290's electronic Medication Administration Record (MAR) revealed the order to place an indwelling catheter was electronically signed as completed by Nurse #6 on [DATE] at 1:30 AM.<br><br>An interview was conducted via phone with Nurse #6 on [DATE] at 5:45 PM. Nurse #6 stated she was assigned to Resident #290 on [DATE] from 7:00 PM to 7:00 AM. Nurse #6 stated Resident #290 was very sick that night. Nurse #6 stated she inserted the catheter and Resident #290 did not have any urinary output from the indwelling catheter. Nurse #6 stated she did not call the on-call provider back to report the lack of urinary output and did not assess the resident for further symptoms.<br><br>Review of Resident #290's progress notes indicated a nursing progress note dated [DATE] at 12:40 PM written by the Nursing Supervisor #2 indicated the resident requested to be sent to the hospital because he was unable to eat or urinate and the NP was notified. The NP indicated the resident was competent and to send him to the ER if that was what he wanted.<br><br>Review of Resident #290's progress notes indicated a nursing progress note dated [DATE] at 2:31 written by Nursing Supervisor #2 indicated resident was sent to the hospital for evaluation at 2:20 PM.<br><br>The Emergency Provider/emergency room Note dated [DATE] indicated the resident arrived in the emergency room and was extremely ill, hypotensive (low blood pressure), hypothermic (low temperature) and had atrial fibrillation (irregular heart rate). Laboratory results at the hospital indicated C. diff was positive, the white blood cell count was 66.0 thousand per microliter and the resident was diagnosed with Septic Shock secondary to C. diff.<br><br>The hospital discharge summary dated [DATE] indicated Resident #290 was admitted on [DATE] with diagnosis of septic shock secondary to C. diff colitis. Resident #290 presented with a chief complaint of persistent diarrhea and dehydration with approximately 1 month of persistent malodorous diarrhea and dehydration. In the emergency department, the resident's blood pressure was ,d+[DATE] and pulse was 110. [NAME] blood count was 66 and resident tested positive for C. diff. The resident was admitted to the intensive care unit where his condition continued to decline. Resident #290 passed away on [DATE] at 11:02 PM.<br><br>Review of Resident #290's death certificate dated [DATE] indicated resident's cause of death was Sepsis, C. diff and acute kidney injury.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0714<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview conducted with the Nurse Practitioner on [DATE] at 3:00 PM revealed he was aware Resident #290 had loose stools during his stay in the facility. The NP revealed there was not a system in place for reviewing the residents he saw and their medical conditions with the Medical Director. The NP further indicated he reviewed residents he evaluated with the Medical Director on an as needed basis. The NP stated he did not think Resident #290's condition warranted consultation with the Medical Director because it did not seem that serious. The NP stated he based his assessment on what the resident told him and what was reported by the nursing staff. The NP indicated he thought the resident was being discharged several times due to potential discontinuation of insurance coverage and he wrote his notes and evaluations based on the resident only being in the facility for rehabilitation and would be returning home. Resident #290 did not in fact discharge from the facility until [DATE] when he was emergently sent to the hospital. The NP stated the resident did not report any problems and he used this as his basis for treatment.<br><br>A telephone interview was conducted with Resident #290's RP on [DATE] at 9:20 AM. The RP stated she visited Resident #290 daily and sometimes twice per day. The RP indicated Resident #290 had frequent loose stools that had a foul odor that was noticeable in the hallway. The RP stated Resident #290 indicated he could not tell when he was urinating or having a bowel movement, that the stools were liquid and would just run out of him. The RP stated when she came in to visit, she had observed him with liquid feces running down his legs and she stated she reported to the nurses multiple times that the resident was having loose stools. The RP stated she talked to the NP frequently and reported to him the loose stools. The RP stated she called the Gastroenterologist to report the loose stools since the NP had not addressed it. The RP stated Resident #290 had a loss of appetite, nausea and stomach pain in the weeks before he went to the hospital. The RP stated she arrived at the facility before the resident left via EMS to go to the hospital and indicated she observed the resident struggling to breathe and he stated he had an infection and knew something was wrong.<br><br>An interview was conducted via phone with the Medical Director on [DATE] at 12:05 PM. The Medical Director stated she was new in the position in the facility and new to working with the NP. She stated she visited the facility weekly mainly to complete the history and physicals for new admissions to meet the regulatory requirements. The Medical Director stated there was not a system in place for reviewing the residents seen by the NP each week. The Medical Director stated she expected she would have been notified by the NP regarding a significant change in a resident's condition including diarrhea, possible dehydration, and infection. The NP had not reported any other residents to her which were of concern. The Medical Director further stated she was not informed of the critical lab value (WBC of 51.3 thousand per microliter), and she would have expected to have been. The Medical Director stated there was not a system to ensure that she was notified of changes in residents including critical labs that were called in to the on-call provider but stated there should probably be a system for this.<br><br>An interview was conducted with the Director of Nursing (DON) on [DATE] at 4:45 PM. The DON stated the NP was in the facility daily during the week and the Medical Director visited weekly. The DON stated she was not aware of what the working relationship was between the Medical Director and the NP. The DON indicated she assumed that changes were reported by the NP to the Medical Director. The DON stated she did not consult the Medical Director and did not know if the NP had consulted the Medical Director.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0714<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A follow up telephone interview with the DON on [DATE] at 2:28 PM revealed prior to this incident, there was no protocol for communication between the Medical Director and the Nurse Practitioner. The DON further stated the Medical Director as the attending physician for the residents makes the regulatory visits and the Nurse Practitioner completes the acute visits. The DON stated the Medical Director, and the Nurse Practitioner were both employed by a contracted company which provided their physician, provider, and on call provider service. The contracted service provided a transcript on Monday mornings of the calls that were received over the weekend from the facility and the response. The Medical Director and the NP receive a copy of the transcript. The facility staff call the DON when a resident is sent to the hospital for evaluation on the weekend or at night. The DON updated the NP on Monday of all residents that were sent to the hospital on the weekends. The DON stated the NP wrote his own orders and progress notes and the attending physician or Medical Director did not sign off on the orders or notes. According to the DON, the Medical Director did not have a system for reviewing the visits the Nurse Practitioner completed.<br><br>The Administrator was notified of immediate jeopardy on [DATE] at 4:45 PM.<br><br>The facility provided the following Acceptable Allegation of Immediate Jeopardy removal.<br><br>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.<br><br>The Nurse Practitioner failed to communicate and collaborate with the Medical Director when Resident #290 had prolonged loose, liquid stools from admission on [DATE] through [DATE]. The Nurse Practitioner was made aware and implemented banana flakes on [DATE] and loperamide on [DATE]. Resident # 290 requested to go to the hospital on [DATE] at 12:40 PM due to not feeling well. Emergency Medical Services transferred resident to the hospital at 2:20 PM where he was diagnosed with Septic Shock Secondary to clostridium difficile. The Hospital Discharge Summary indicated Resident #290 died on [DATE] at 11:02 PM. All residents being seen by a Nurse Practitioner and/or Physician Assistant for acute change in condition have the potential to be affected. On [DATE] the Medical Director will review the provider notes for all residents with a change in condition that were seen by any of the Nurse Practitioners and/or Physician Assistants since [DATE]. Any new orders or suggestions made by the Medical Director will be communicated to the Nurse Practitioner/Physician Assistant and the Director of Nursing on [DATE] for follow-up.<br><br>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.<br><br>The Medical Director educated all Providers working with the facility on the clostridium difficile protocol. The protocol indicates that residents with three or more watery or loose stool in a 24 hour time span should have a medication review to ensure laxatives are not contributing to the loose stool. If the loose stool does not resolve within 24 hours of the laxatives being stopped or the resident was not receiving laxatives, a clostridium difficile test will be performed. The NP was included in the provider education. All education was implemented on [DATE] via telephone or face to face training and will be completed by [DATE].<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0714<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] the Director of Nursing was educated by the Regional Director of Clinical Services on providing the Medical Director with a list of residents that were seen by a Nurse Practitioner and/or Physician Assistant in the previous seven days, due to a change in condition, weekly for the Medical Director to review. The Director of Nursing will review all progress notes weekly to determine the residents that were seen in the past 7 days for a change in condition. The Medical Director will review the Nurse Practitioner and/or Physician Assistant progress notes weekly and communicate any suggestions to the Nurse Practitioners and/or Physician Assistants and the facility. The Regional Director of Clinical Services communicated the new review process to the provider groups Nurse Practitioners and/or Physician Assistants as well on [DATE]. The Medical Director was informed of the new review process by the Director of Nursing on [DATE] and is in agreement with the system of communication and collaboration.<br><br>Alleged Date of immediate jeopardy removal: [DATE]<br><br>The credible allegation of immediate jeopardy removal was validated on [DATE]. Interviews with the Nurse Practitioner, Physician Assistant, Medical Director and the Director of Nursing revealed they received education and training regarding the new process of checking residents' progress notes for significant changes. The Director of Nursing will provide the Medical Director with a list of all residents with significant changes for review. The Medical Director validated that she will review the progress notes of all residents with significant changes and communicate suggestions or changes in plan of care to the Nurse Practitioners, Physician Assistant and the facility. The Regional Clinical Consultant confirmed that she educated the Director of Nursing on the new process and auditing to be completed. The immediate jeopardy removal date of [DATE] was validated. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173<br><br>Based on observations, record review, and staff, Consulting Pharmacist, Psychiatric Physician Assistant, and the Medical Director interviews the facility failed to ensure an antianxiety medication was available from the pharmacy to administer as ordered by the physician resulting in 3 missed doses for 1 of 5 residents (Resident #53) reviewed for medication administration.<br><br>Findings included:<br><br>Resident #53 was admitted to the facility on [DATE]. Diagnoses included anxiety disorder.<br><br>A physician order was written on 04/30/24 for Lorazepam (medication to treat anxiety) 0.5 milligrams (mg) three times a day for anxiety disorder.<br><br>A progress note written on 01/10/25 by Nurse #4 revealed Resident #53 missed dose of Lorazepam due to medication being out. The note stated the Physician and Responsible Party were aware and that Nurse #4 spoke with the pharmacy and they stated they would send the medication out tonight (01/10/25).<br><br>Review of the medication administration record (MAR) revealed on 01/10/25 Resident #53 was not given her 8:00 AM dose, 2:00 PM dose and 8:00 PM dose of Lorazepam 0.5 mg as evidenced by the nursing initials by Nurse #4 and Nurse #13 being in parenthesis.<br><br>Review of the facility's automated medication dispensing machine inventory log on 01/10/25 revealed Lorazepam 0.5 mg was listed as a medication to be available. The inventory log revealed that the amount to be available for use was 8 tablets, but the quantity on hand was recorded as 0.<br><br>An interview with Nurse #4 on 02/05/25 at 3:20 PM revealed she worked on 01/10/25 and did not administer the prescribed Lorazepam to Resident #53 at 8:00 AM and 2:00 PM because the facility ran out of the medication. She stated she documented on the MAR it was not administered by putting parentheses around her initials. Nurse #4 stated Nurse #6 (nurse who worked on 01/09/25 from 7:00 PM - 7:00 AM) reported to her the morning of 01/10/25 that she notified Nurse Practitioner (NP) #1 that Resident #53 ran out of the Lorazepam and Nurse #6 told NP #1 he needed to do an escript to get it refilled. Nurse #4 stated she looked in the automated medication dispenser to see if there was any Lorazepam 0.5 mg tablets and there were none. Nurse #4 stated she notified the pharmacy that Resident #53 was out of Lorazepam and the pharmacy reported they had received the escript and were filling the order. Nurse #4 stated the pharmacy informed her that it would be delivered on the truck that went out that evening (01/10/25). Nurse #4 stated she passed on in report to the oncoming nurse (Nurse #13) that Resident #53 did not have any more Lorazepam 0.5 mg tablets and that the medication was being delivered sometime that evening. Nurse #4 stated the nurse on the medication carts were responsible for making sure Resident #53 had enough Lorazepam to be administered to ensure she did not run out of her medication. Nurse #4 stated the medication should have been reordered when the dispensing card indicated the medication was running low to prevent from running out of the medication.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Evening Supervisor Nurse on 02/05/25 at 3:30 PM. The Evening Supervisor Nurse stated the usual process for ordering controlled medications was that on Thursday or Friday before the weekend she would go through the medication carts to see which residents were due for a refill. She stated she would make a list and give it to NP #1 for him to write an escript and forward to the pharmacy. She stated the week of 01/10/25 she was out sick and she did not get the list for the NP. She stated although she did not get this list, it was ultimately up to the floor nurses to check their medications carts to see if they needed any refills of the controlled medications and to provide that list to the NP.<br><br>An interview was conducted with the Psychiatric Physician Assistant (PA) via phone on 02/05/25 at 11:52 AM. The PA stated if the Lorazepam 0.5 mg was not available in the automated medication dispenser he would have expected the nurse to let him or the provider know what was available. At this time, the PA was made aware that Alprazolam 0.5 mg and Lorazepam IM 2mg/2ml were available in the automated medication dispenser. The PA stated if he were notified on 01/10/25 that the facility ran out of the Lorazepam, he would have modified the order and had the nurse administer Alprazolam at a lower dose since it was a stronger medication until her Lorazepam arrived to the facility.<br><br>An interview was attempted via phone to Nurse #6 on 02/10/25 at 3:30 PM. Left message for returned call. Nurse #6 returned the call on 02/13/25 at 12:57 PM. An interview with Nurse #6 revealed on the night of 01/09/25 she administered the last dose of Lorazepam to Resident #53. She stated she notified NP #1 to do an escript because she had administered the last dose. Nurse #6 reported that the nurse on the medication cart was responsible for ensuring that there was enough of the medication on hand to be administered before the resident would need a refill. Nurse #6 stated she would check her cart on Thursdays and if the count of the medication was down to enough to administer for 4 days she would request an escript to be sent. Nurse #6 stated she did not know how it got overlooked for this medication not to be reordered. Nurse #6 stated usually there was Lorazepam 0.5 mg tablets in the automated medication dispenser, but if there were none available, she would check to see what other medications were available and could be considered to treat anxiety and get an order from the Physician to administer another medication until her medication arrived from pharmacy.<br><br>An interview was conducted with the Pharmacy Manager via phone on 02/07/25 at 3:42 PM. The Pharmacy Manager stated she received an escript on 01/09/25 and the Lorazepam 0.5 mg tablets were sent out for delivery on 01/10/25 at 10:00 PM. The Pharmacy Manager stated if the medication was sent out for delivery from the pharmacy at 10:00 PM it was likely that it would not arrive to the facility until after midnight on 01/11/25. The Pharmacy Manager stated it can take up to 2 days to have the medication ready to be delivered and the facility should consider the time it takes to get medications delivered when refilling the prescription so they do not run out of the medication to be given.<br><br>An interview was conducted with Nurse Practitioner (NP) #1 on 02/07/25 at 2:39 PM. NP #1 stated the nurses usually would give him a list of what prescriptions they needed refilled and then he would write an escript and send it to the pharmacy. NP #1 stated he did not recall giving any other orders when the nurse notified him that the Resident was out of her Lorazepam.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Director of Nursing (DON) on 02/07/25 at 5:15 PM. The DON reported she expected her nursing staff to be mindful of when controlled medications needed to be refilled and request an escript sooner than later so that residents do not go without their medication due to waiting for deliveries. The DON added each medication administration card has a color coded blue reorder line and nurses should be ordering before or at the line. The DON stated that there were other options in the automated medication dispenser Nurse #4 could have considered to get an order for to include Alprazolam and IM Lorazepam. The DON stated she would have expected Nurse #4 to let the provider be aware of what else was available in the automated medication dispenser to see if something else could have been ordered and administered.<br><br>An interview was conducted with the Medical Director via phone on 01/10/25 at 4:30 PM. The Medical Director stated she was concerned that the facility was running out of medications and this was a reoccurring event and that controlled medications were not being filled in a timely manner. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44890<br><br>Based on record review and Nurse Practitioner (NP), Medical Director, Consulting Pharmacist, Pyschiatric Physician Assistant, and staff interviews, the facility failed to prevent significant medication errors for 2 of 6 residents (Resident #241 and Resident #53) whose medications were reviewed. Nurse #12 administered medications to Resident #241 that were prescribed for Resident #295. The medications included amlodipine (used to treat blood pressure)/ valsartan (used to treat blood pressure), carvedilol (beta blocker used to treat blood pressure), duloxetine (used to treat depression), gabapentin (used to treat pain), memantine (used to treat dementia) and roflumilast (used to treat inflammation in chronic obstructive pulmonary disease). Resident #241 had no significant adverse effects as a result of the error. Additionally, the facility failed to administer Resident #53 a physician ordered antianxiety medication resulting in 3 missed doses.<br><br>The findings included:<br><br>1) Resident #241 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction (stroke), aphasia (difficulty with speech), and hemiplegia (muscle weakness affecting one side of the body) and hemiparalysis (paralysis on one side of the body).<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #241 was severely cognitively impaired.<br><br>The physician orders for Resident #241 for November 2024 included the following medications scheduled for morning medication pass 7:00 AM to 11:00 AM:<br><br>-aspirin tablet, delayed release 81 milligrams (mg) 1 tablet by mouth for stroke and peripheral vascular disease.<br><br>-baclofen 20 mg 1 tablet by mouth for muscle spasms<br><br>-citalopram 20 mg 1 tablet by mouth for depression<br><br>-levetiracetam 1000 mg tablet give 1 tablet by mouth for seizures<br><br>-senna 8.6 mg tablets give 2 tablets for constipation<br><br>-topiramate 25mg tablet give 1 by mouth for seizures<br><br>The physician's orders for Resident #241 revealed he was not prescribed any antihypertensives (medications to treat blood pressure).<br><br>The November 2024 Medication Administration Record (MAR) for Resident #241 revealed he was administered his morning medications by Nurse #12 on 11/18/2024.<br><br>Resident #295 was admitted to the facility on [DATE].<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #295's Medication Administration Record included the following medications scheduled to be administered during the morning medication administration pass:<br><br>-amlodipine-valsartan tablet 10-320 milligrams (mg) tablet by mouth for hypertension<br><br>-carvedilol 25 mg tablet by mouth for hypertension<br><br>-duloxetine capsules 30 mg by mouth for depression<br><br>-gabapentin 600 mg tablet by mouth for pain<br><br>-memantine 5 mg tablet by mouth for dementia<br><br>-roflumilast 500 micrograms (mcg) tablet by mouth<br><br>-nicotine patch 24 hour; 21mg/24 hour; 1 patch transdermal (to skin) (used to treat nicotine withdrawal).<br><br>A progress note written by Nursing Supervisor #3 on 11/18/2024 at 12:52 PM, indicated Resident #241 had received the wrong morning medication. Nurse Practitioner (NP) #1 was notified and ordered neuro checks every 2 hours for 24 hours and vital signs every 2 hours for 24 hours. Resident #241's vital signs were recorded as blood pressure 134/65, pulse 47, respirations 18 and oxygen saturation 99%. Resident #241 was not showing any adverse effects from the medication.<br><br>A telephone interview was completed with Nursing Supervisor #3 on 2/4/2025 at 4:28 PM. Nursing Supervisor #3 stated that the medication error occurred while Nurse #7 was orientating Nurse #12. She further stated that Nurse #7 had prepared the medications for Resident #295 and then had to go to the medication storage room to retrieve a nicotine patch. The Nursing Supervisor indicated Nurse #7 instructed Nurse #12 to administer the medications to Resident #295's room number, but instead, she administered them to Resident #241 in the next room. Nursing Supervisor #3 stated they immediately informed NP #1, and he came and assessed Resident #241, and the nurses monitored him closely. She further stated she no longer worked at the facility and could not remember the medications he received.<br><br>An Event Report completed by Nursing Supervisor #3 for a Medication Error dated 11/18/2024 at 11:00 AM read in the description of error that Resident #241 was given Resident #295's morning medications.<br><br>A review of the neuro checks and vital signs performed by the nurses for Resident #241 following the medication error on 11/18/24 were within normal limits.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A telephone interview was completed with Nurse #7 on 2/5/2025 at 8:16 AM. Nurse #7 stated that on 11/18/2024 she was orienting Nurse #12 during the morning medication pass. She further stated that Nurse #12 had been in orientation for a couple of weeks. Nurse #7 indicated that she prepared the medications for Resident #295 and then realized she needed a nicotine patch from the medication storage room. She further indicated that Nurse #12 was standing right beside her when she was preparing the medications and thought she knew which resident they belonged to. She stated she instructed Nurse #12 to take the medications to Resident #295's room, but instead she went into the room next to it and administered them to Resident #241. Nurse #7 further stated that they had reported the incident immediately to Supervisor #3 and NP #1 and monitored Resident #241 closely. She indicated that since she was the nurse who prepared the medications, she should have administered the medications, and she should not have let a nurse in orientation go by herself to administer medications. Nurse #7 stated that Resident #241 was administered his morning medications on 11/18/2024.<br><br>A telephone interview was completed with Nurse #12 on 2/5/2025 at 10:57 AM. Nurse #12 stated that she was in orientation at the facility on 11/18/2024 with Nurse #7. She further stated that Nurse #7 was in a hurry when she was preparing the medications, and she told her to take the medications to the wrong room number. Nurse #12 stated she could not remember the room number or the medications. She further stated that the resident was fine and had not suffered any ill effects from the medication. Nurse #12 indicated that she could understand Nurse #7 and there was no communication problem between them. She further indicated that she should not have administered the medications because she was not the nurse that prepared them.<br><br>A progress note written by NP #1 on 11/18/2024 read in part that Resident #241 was being seen for a medication error that just occurred. It further read that Resident #241 received the wrong medications including amlodipine, valsartan, carvedilol, duloxetine, gabapentin, and roflumilast. NP #1 documented that Resident's #241's heart rate did dip into the high 40's (normal 60-100) and his blood pressure was 108/54 (normal 120/80) . The plan indicated that the nursing staff was to monitor the resident's vital signs and neuro checks every 2 hours for 24 hours, and there were no adverse effects at the time. The vital signs for Resident #241 were listed as blood pressure 123/58, pulse 56, respiratory rate 18 breaths per minute, and oxygen saturation 96%.<br><br>An interview was completed with NP #1 on 2/5/2025 at 9:50 AM. NP #1stated that Resident #241 was given the wrong medication by a nurse that was in training. He further stated that Resident #241 received a couple of blood pressure medications, and this was concerning because he was not on any antihypertensive medications. NP #1 indicated he was immediately made aware of the situation and he went and assessed Resident #241 for any blood pressure changes, syncope (fainting), dizziness, or any mental status changes. He further indicated he was concerned about orthostatic changes (drop in blood pressure when going from sitting to standing position) and didn't want him to have a fall. NP #1 stated that if something was going to happen it would happen in the first 6-8 hours. He further stated he had ordered the nurses to monitor him closely and obtain his vital signs every 2 hours and neuro checks every 2 hours for 24 hours. NP #1 stated that Resident #241 did not have any lasting effect from the medications, just a temporary decrease in heart rate and blood pressure that had not warranted further treatment.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A telephone interview was conducted with the Consulting Pharmacist on 2/7/2025 at 12:57 PM. The Consulting Pharmacist stated that if someone was administered amlodipine, valsartan, and carvedilol, the biggest concern would be for a drop in the blood pressure. He further stated it could be significant if the blood pressure or pulse dropped too fast and the person had syncope (fainting) episode and the person fell . The Pharmacy Consultant indicated that receiving all 3 blood pressure medications at the same time would not cause any lasting long-term effects. He stated as for the duloxetine, gabapentin, and memantine, these medications might make someone feel drowsy, groggy, or sleepy, but no long-term effects. The Consulting Pharmacist further stated that the only common side effect for roflumilast was weight loss, and one dose would not cause any effects, and neither would the vitamins.<br><br>An interview was completed with the Medical Director on 2/7/2025 at 4:26 PM. The Medical Director stated the biggest concern with the medications that Resident #241 received were the blood pressure medications. She further stated that Resident #241 was not receiving any blood pressure medications at that time and receiving 3 blood pressure medications that even at their lowest dosages could lower his blood pressure significantly. The Medical Director indicated the most important thing would be to monitor his vital signs closely for several hours. She further indicated that the other medications he received probably had no effect on him because of his cognitive status.<br><br>An interview was conducted with the Director of Nursing (DON) on 2/5/2025 at 10:35 AM. The DON stated the medication error involving Resident #241 on 11/18/2024 occurred when Nurse #12, who was in orientation, administered him another resident's medications. She further stated that Nurse #12 was in orientation for about 6 weeks when the incident occurred, and that she was having some difficulty learning the long-term care environment. The DON indicated that Nurse #7 was orientating Nurse #12 during the morning medication administration pass on 11/18/2024. She further indicated that Nurse #7 prepared Resident #295's medications and then realized she needed a nicotine patch from the medication storage room. The DON stated Nurse #7 instructed Nurse #12 to administer the medication to Resident #295's room number, but she went to the room next to it and administered the medications to Resident #241. She further stated the nurses had immediately reported the error to Unit Supervisor #3 and NP #1. The DON indicated NP #1 had assessed Resident #241 and wrote orders to monitor his vitals and perform neuro checks every 2 hours for 24 hours. She indicated that mistakes happen, but fortunately he did not experience any negative effects from the medications. She further stated that Nurse #7 should not have let a nurse in orientation go by themselves to pass medications.<br><br>An interview was completed with the Administrator on 2/5/2025 at 10:45 AM. The Administrator stated that the medication error that involved Resident #241 was just a mistake and that it was an unfortunate incident that occurred. He further stated that he expected the nurses to give the right medications to the correct resident.<br><br>35173<br><br>2) Resident #53 was admitted to the facility on [DATE]. Diagnoses included anxiety disorder and depression.<br><br>A physician order was written on 04/30/24 for Lorazepam (medication to treat anxiety) 0.5 milligrams (mg) three times a day for anxiety disorder.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Minimum Data Set significant change assessment dated [DATE] revealed the resident was moderately cognitively impaired and did not demonstrate behaviors during this assessment. She received antipsychotics, antianxiety, and antidepressant medications.<br><br>A progress note written on 01/10/25 by Nurse #4 revealed Resident #53 missed dose of Lorazepam due to medication being out. The note stated the Physician and Responsible Party were aware and that Nurse #4 spoke with the pharmacy and they stated they would send the medication out tonight (01/10/25).<br><br>Review of the medication administration record (MAR) revealed on 01/10/25 Resident #53 was not given her 8:00 AM dose, 2:00 PM dose and 8:00 PM dose of Lorazepam 0.5 mg as evidenced by the nursing initials by Nurse #4 and Nurse #13 being in parenthesis.<br><br>Review of the facility's automated medication dispensing machine inventory log on 01/10/25 revealed Lorazepam 0.5 mg was listed as a medication to be available. The inventory log revealed that the amount to be available for use was 8 tablets, but the quantity on hand was recorded as 0. The inventory log also revealed that there was a total of 4 vials of Lorazepam 2 milligrams per milliliter (mg/ml) available on hand and 10 tablets of Alprazolam (medication to treat anxiety) 0.5 mg available on hand.<br><br>Review of nursing progress notes on 01/10/25 and 01/11/25 revealed there was no documentation regarding monitoring Resident #53's behaviors related to not receiving her scheduled Ativan.<br><br>An interview with Nurse #4 on 02/05/25 at 3:20 PM revealed she worked on 01/10/25 and did not administer the prescribed Lorazepam to Resident #53 at 8:00 AM and 2:00 PM because the facility ran out of the medication. She stated she documented on the MAR it was not administered by putting parentheses around her initials. Nurse #4 stated Nurse #6 (nurse who worked on 01/09/25 from 7:00 PM - 7:00 AM) reported to her the morning of 01/10/25 that she notified Nurse Practitioner (NP) #1 that Resident #53 ran out of the Lorazepam and Nurse #6 told NP #1 he needed to do an escript to get it refilled. Nurse #4 stated she looked in the automated medication dispenser to see if there was any Lorazepam 0.5 mg tablets and there were none. Nurse #4 stated she should have made NP #1 aware that Alprazolam 0.5 mg tablets and Intramuscular Lorazepam 2 mg/ml vials were available in the automated medication dispenser as an alternative antianxiety medication for Resident #53 but she did not think of it. Nurse #4 stated she notified the pharmacy that Resident #53 was out of Lorazepam and the pharmacy reported they had received the escript and were filling the order. Nurse #4 stated the pharmacy informed her that it would be delivered on the truck that went out this evening (01/10/25). Nurse #4 stated she monitored Resident #53 for any signs or symptoms of withdrawal or increased anxiety during her shift from 7:00 AM to 7:00 PM and Resident #53 had no symptoms. Nurse #4 stated she passed on in report to the oncoming nurse (Nurse #13) that Resident #53 did not have any more Lorazepam 0.5 mg tablets and that the medication was being delivered sometime this evening. Nurse #4 stated she reported to the oncoming nurse to monitor for any signs of increased anxiety. Nurse #4 stated the nurse on the medication carts were responsible for making sure Resident #53 had enough Lorazepam to be administered to ensure she did not run out of her medication. Nurse #4 stated the medication should have been reordered when the dispensing card indicated the medication was running low to prevent from running out of the medication.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Psychiatric Physician Assistant (PA) via phone on 02/05/25 at 11:52 AM. The PA stated Resident #53 should not go without her Lorazepam; and as a result of missing 3 doses of the Lorazepam, Resident #53 was at risk for Lorazepam withdrawal. The PA stated with missing her prescribed doses for one day the withdrawal effects would be minor and she could have demonstrated increased anxiety. The PA stated he would expect that since Resident #53 had not received the prescribed anti-anxiety medication that she would be monitored for any signs and symptoms of withdrawal.<br><br>An interview was attempted via phone to Nurse #13 who worked 7:00 PM to 7:00 AM on 01/10/25 into 01/11/25, but she did not return the call.<br><br>An interview was attempted via phone to Nurse #6 on 02/10/25 at 3:30 PM. Left message for returned call. Nurse #6 returned the call on 02/13/25 at 12:57 PM. An interview with Nurse #6 revealed on the night of 01/09/25 she administered the last dose of Lorazepam to Resident #53. She stated she notified NP #1 to do an escript because she had administered the last dose. Nurse #6 reported that the nurse on the medication cart was responsible for ensuring that there was enough of the medication on hand to be administered before the resident would need a refill. Nurse #6 stated she would check her cart on Thursday and if the count of the medication was down to enough to administer for 4 days she would request an escript to be sent. Nurse #6 stated she did not know how it got overlooked for this medication not to be reordered. Nurse #6 stated usually there was Lorazepam 0.5 mg tablets in the automated medication dispenser, but if there were none available, she would check to see what other medications were available and could be considered to treat anxiety and get an order from the Physician to administer another medication until her medication arrived from pharmacy.<br><br>An interview was conducted with the Consulting Pharmacist via phone on 02/07/25 at 1:09 PM. The Consulting Pharmacist stated he would be concerned with Resident #53 missing 3 doses of Lorazepam as she could have increased anxiety as a result of withdrawal. He stated he would expect the nursing staff to be monitoring the resident for any adverse effects from not having her Lorazepam. He also stated he would have expected the nursing staff to see what was available in the automated medication dispenser to be administered so there was no delay in the resident receiving her anti-anxiety medication.<br><br>An interview was conducted with Nurse Practitioner (NP) #1 on 02/07/25 at 2:39 PM. NP #1 stated he did not recall giving any other orders when the nurse notified him that the Resident was out of her Lorazepam, but that he should have let the nurse know that another medication such as Alprazolam, at an equivalent dose, available in the automated medication dispenser could have be given until the Resident #53's medication arrived from pharmacy. NP #1 stated there were other options to consider administering to prevent the resident from having any potential increased anxiety or withdrawals.<br><br>An interview was conducted with the Medical Director via phone on 01/10/25 at 4:30 PM. The Medical Director stated it was not really concerning to her that Resident #53 missed 3 doses of the Lorazepam. She stated, however, it was concerning that the facility was running out of medications and this was a reoccurring event and that controlled medications were not being filled in a timely manner. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44890<br><br>Based on observations, record review, and staff interviews, the facility failed to: 1) remove expired medications in accordance to the manufacturer's expiration date for 1 of 3 medication carts (Medication Cart #4); 2) remove loose pills of various sizes, colors, and shapes from 2 of 3 medication carts (Medication Cart #2 and Medication Cart #4); and 3) failed to secure medications observed at the bedside for 1 of 1 severely cognitively impaired resident (Resident #59) reviewed for medication storage.<br><br>Findings included:<br><br>1.) An observation was conducted on 2/5/2025 at 1:45 PM of Medication Cart #4 in the presence of Nurse #7. The observation revealed 3 white pill halves were found loose in the drawers. The observation further revealed 7 doses of the stock medication loperamide Hydrochloride (HCL) 4 milligrams (mg) (an antidiarrheal medication) in individual blister packs with the manufacturer's expiration date of 12/2023 and 5 doses of loperamide HCL 4mg tablets with the manufacturer's expiration date of 9/2024.<br><br>An interview was completed with Nurse #7 on 2/5/2025 at 1:45 PM. Nurse #7 stated there should not be any expired medications or loose pills on the cart. She further stated that it was the nurse's responsibility to check the carts for expired medications.<br><br>2.) An observation was conducted on 2/5/2025 at 12:45 PM of Medication Cart #2 in the presence of Nurse #8. The observation revealed 12 loose pills of various colors, shapes, and sizes were found in the drawers of the cart.<br><br>An interview with Nurse #8 was completed on 2/5/2025 at 12:45 PM with Nurse #8. Nurse #8 stated that there were not supposed to be any loose pills on the cart. She further stated she had recently cleaned the cart, but pills could just pop out of the blister packs when placing them in or taking them out of the cart.<br><br>An interview was completed with the Director of Nursing on 2/7/2025 at 1:30 PM. The DON stated there was not supposed to be any expired medications on the cart. She further stated that Pharmacy and the nursing staff had recently checked all the carts for expired medications, and she was not sure why the expired medications were not removed. The DON explained there should not be any loose pills in the carts, but sometimes they just popped out the blister packs during medication administration. She further explained it was the nurses' responsibility to check their carts frequently and to keep their carts clean and remove expired medications.<br><br>40044<br><br>3.) Resident #59 was admitted to the facility on [DATE] with diagnoses including Atrial fibrillation, chronic obstructive pulmonary disease (COPD), and hypertension.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #59 was severely cognitively impaired.<br><br>During an observation on 02/04/25 at 12:15 PM a medication cup with 3 pills was observed on Resident #59's bedside table. Resident #59 stated the nurse brought them in earlier that morning.<br><br>During an interview on 02/04/25 at 12:15 PM Nursing Supervisor #2 stated she completed Resident #59's medication pass at 9:50 AM today. She stated she went into his room and gave him his medications. She left the room to get his nutritional supplement and when she returned to the room, she thought he had taken all his medications. She stated the pills that were left in the medication cup at the bedside included Xarelto (anticoagulant), Losartan (antihypertensive), and Prednisone (corticosteroid used to treat inflammation). She stated she should have waited and observed him take all the medications before she left his room.<br><br>During an interview on 02/07/25 at 4:56 PM the Director of Nursing stated the nurse should ensure that residents take all of their medications prior to leaving the room. She stated education would be provided. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173<br><br>Based on observations, record review and staff interviews the facility failed to remove expired food items stored for use in the dry storage room and remove expired food items from 1 of 2 nourishment rooms. This practice had the potential to affect the food served to 92 out of 92 residents.<br><br>Findings included:<br><br>a. An initial tour of the facility's dry storage room on [DATE] at 11:00 AM with the Dietary Manager revealed the following expired items:<br><br>- Twelve bottles of 14.5 fluid ounces of sugar free breakfast syrup expired on [DATE]<br><br>- Four - 16 ounce bags plus ,d+[DATE] bag (8 ounces) of corn chips expired on [DATE]<br><br>- One case with approximately 200 single packaged chocolate chip cookies in the case had expired on [DATE]<br><br>- Ten - 24 ounces fruit punch powder mix 1lb. each with no expiration date. The packages were noted to be hard to touch and not soft and powdery.<br><br>An interview with the Dietary Manager on [DATE] at 11:20 AM revealed she removed the syrup, corn chips and cookies from the dry storage and discarded them. She stated she did not know how long the fruit punch powder was stored in the dry storage area as it had no arrival date when received recorded on the packages and she had no idea how long they were sitting on the shelf. The Dietary Manager discarded the fruit punch powder mixes. She stated the stock was rotated weekly when the new delivery arrived. She stated she or the cook would rotate the stock to ensure there were no expired items or put the soon to be expired product in the front of the shelf to be used. The Dietary Manager stated the above items were overlooked and she would begin an in-service immediately.<br><br>b. A tour of the nutrition rooms were conducted on [DATE] at 12:45 PM and the following was noted in 1 of 2 nutrition rooms:<br><br>- The refrigerator temperature in the refrigerator labeled for resident's use only was 22 degrees Fahrenheit.<br><br>- There were five (5) frozen 8 ounce bottles of supplemental shakes which had expired on [DATE].<br><br>- Five - 8 ounce bottles of supplemental shakes that had expired on [DATE] but were not frozen.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | An interview was conducted with the Dietary Manager on [DATE] at 12:45 PM. She revealed the Dietary Aide was responsible for ensuring the temperatures in the refrigerator were within acceptable range and removing any expired products. The Dietary Manager provided a log to indicate the nutrition room had been checked on [DATE] for the AM and PM shift, but the expired products were not removed. The Dietary Manager stated the Dietary Aide obviously overlooked it and she would start an in-service immediately. The Dietary Manager stated those products should have been removed from the refrigerator. The Dietary Manager stated the manufacturer's label did not indicate a do not freeze on the supplement shake bottle, but they still should have been removed because they were expired. She stated the Dietary Aide should have checked the temperature in the refrigerator to ensure it was at 35 - 38 degrees Fahrenheit.<br><br>On [DATE] at 12:45 PM, the Dietary Aide who signed the log was not available for an interview.<br><br>An interview was conducted with the Administrator on [DATE] at 5:30 PM. The Administrator stated he expected the kitchen Dietary Manager and the dietary staff to be following the guidelines to discard expired food items from the kitchen as well as the nutrition rooms. He stated expired foods could cause potential food borne illness to residents. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345575 | A. Building<br>B. Wing | 02/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brunswick Health & Rehab Center | 9600 No 5 School Road<br>Ash, NC 28420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>40044<br><br>Based on observations, record review, and staff interviews, the facility failed to implement the facility's infection control policy and procedures for Enhanced Barrier Precautions (EBP) when the Wound Nurse provided wound care for Resident #81's chronic wounds wearing gloves but no gown. This occurred for 1 of 3 staff observed for infection control practices (Wound Nurse).<br><br>Findings included:<br><br>The facility's Infection Control Policy revised 04/15/24 revealed Enhanced Barrier Precautions (EBP) were intended to prevent transmission of multi drug resistant organisms (MDRO's) via contaminated hands and clothing to high-risk residents. EBP were indicated for high contact care activities for residents with chronic wounds and indwelling devices.<br><br>An observation of Resident #81 was conducted on 02/06/25 at 10:00 AM with the Wound Nurse. Resident #81 was noted to have multiple areas of open wounds on the left posterior lower extremity, bilateral great toes, and bilateral knees. There was no sign placed to indicate that Resident #81 was on Enhanced Barrier Precautions. There were no supplies near Resident #81's room to don prior to providing direct care. The Wound Nurse donned gloves prior to removing the dressing on the left posterior lower extremity wound but did not don a gown. She described the wound on the left lower extremity as a Stage IV wound. When asked if she should wear personal protective equipment (PPE) to include a gown and gloves prior to removing a dressing she stated she thought enhanced barrier precautions were only needed for residents with chronic wounds.<br><br>During an interview with the Infection Control Preventionist Nurse on 02/06/25 at 11:00 AM she stated residents that received wound care should be placed on enhanced barrier precautions. She stated Resident #81 was admitted with chronic wounds. He was placed on enhanced barrier precautions on admission, but he contracted COVID during the current COVID outbreak in the facility, and he was placed on contact precautions. She stated after he came off contact precautions last week they forgot to continue the enhanced barrier precautions. She stated she would review all residents with wounds or an indwelling device to ensure they were on enhanced barrier precautions.<br><br>During an interview on 02/07/25 at 4:00 PM the Director of Nursing (DON) stated staff had been trained on enhanced barrier precautions and were aware that residents receiving wound care to chronic wounds should be placed on enhanced barrier precautions. She stated the wound nurse should have donned a gown and gloves prior to wound care. She reported education would be provided. |